Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #2 per MD G901 3/11/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar 0500 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 20 SEPHINE AVIS 82 0200 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 114 N. Meadow Drive Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day Year) 1 - M 2 Months Days Hours Min 173-14-0304 89 Pennsylvania Director 1920 Aug. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 🗌 Yes 2 🔀 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 114 N. Meadow Drive United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas F. Sechrist Lura K. Kaiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. Stanley Davis/ Son 114 N. Meadow Dr., Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Feb 20104, Moreland Mem. Park Parkville, Maryland neral Service Lidensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Sig W 30 MD 21061 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ns an and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PER TENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4-Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ဂ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Frantioger: To the best of my knowledge, doeth or diet the time date and clare and due to the 29b. Signature and title of cartifi 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Typer Print) Name and address of per DEFENSE HIGHWAY ANNAPOLIS WYYT 32 egistrar's Signatu State Registrar

DHMH 17 Rev 7/2009

05002 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 | 0

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 12, 2010 1433 hrs ∜cal Examiner 1)1000 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** 6. Sex 7, Age (In yrs, last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Country) 1 X M Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 2/239 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 1 X Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 ather's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname elationship (Type, Print) r or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation Removal from State Other Specify MO 1560 Part I. Enter the disease, or complications that caused the death, Do not enter the proximate Interval hysician Between Onset and /Medical Death a Hypertensive athoersclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) complicating drug use Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDE 23a, PII, 27, perME, G901 3/3/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Yes 2 ✓ No 3 Probably 4 Unknown Diabetes; Hepatitis C Completed After this certificate has been funeral director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 V No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No 5 Pending Director; d in by the f Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe O.C.M.E. February 17, 2010 30. Name and address of cause of death (Item 23a)

31. Date filed (Month, Day, Year) FEB 23

Jack Titus MD. Deputy Chief Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

OCME

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Z eininger 37 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BACTIHORE AA COUN NASHINGTON MEDICAL CON GIEN Age (In yrs. last birthday) Social Security Numbe 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Illinois 8. Date of Birth 1 □ M 2 🖾 F 185-24-3348 Months Days Hours Min. Manth, Day Yearly 29 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 🗌 Yes 2 🖳 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8349 Fairwood Drive 21122 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white If Yes, Give 3 🗷 Widowed 4 🗌 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 music teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Effting Dorothy Kaszunski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste Coffelt 8349 Fairwood Drive Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Nisky Hill Cemetery 2/25/10 Bethlehem PA 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stallings Funeral HomeP.A. Pasadena MD 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examir that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performer death? Kidne hronic 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28b. Time of

Examiner Box 68760 P.O. I Records, **Division of Vital**

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the burial signed by the a peen page 2 has certificate funeral director, After this within 24 hours after death.

To the Funeral Director: All completed filled in by the fu death.

Funeral

Director

28a-f show the Maryland

ral", or items 23a or 28a-f sho Examiner must be notified at

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"natural",

injury or other traumatic event, the Medical

filed within 72 hours after death with

2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r

permit. Page 1 and 2 st Department of Heatth a Important: If item 27 is any injury or other trau

Physician

Medical

Baltimore, Maryland 21215-0036

28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 \square Pending work 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print) 8028 M.D 31. Date filed (Month, Day, Year) 32. Registra FEB 23 2010

Medical

29a, Certifie

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d	Medic Examin		4a. Facility Name (if not institution, give street	and number)			or Location of De		4c. County of Death				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	Glen Bu	r If Under 24 H			Anne Arundel 9. Birthplace (State or Foreign			
	Director		Usual Residence of Decedent	₹ 66	Yrs.	Months Days	B Hours M	ay, Year	3	MD MD			
	th with the Maryland ms 23a or 28a-f show must be notified at	ctor	10a. State 10b. County		, Town or Loc	ation					10d. Inside City Limits		
	the Ma or 28a e notif	Funeral Director	10e. Street and Number	incel Glen	Burnie	10f. Zip Code			10g. (Citizen of What	1 XYes 2 ☐ No Country?		
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980	s after dea al", or ite Examiner	b	1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces? ☐ Yes 2 ☑ No Yes, Give ear or Dates.	If	Vas Decedent of Yes, specify Cul	Hispanic Origin? ban, Mexican, Pu lo Specify:	(Specify Yes or No erto Rican, etc.)	D-	Black, W	e - American Indian, k, White, etc.		
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Maryland 21215-0036	uld be filed Mental Hy narked ott	To Be	17. Father's Name (First, Middle, Last) Edward H. Kraft, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Josephine M. Valenzia										
	permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical.		19a. Informant's Name/Relationship (<i>Type, Pr</i> Sherrie Link Daugl	•			tand Number or Lane, Gler		-		Zip Code)		
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otl		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specification)	val from State ce	metery, ocem	sition (Name of latory or other pl Cemetery	^{ace)} Feb	Date 23, 2010		Location - City n Burnie			
Balt	permit Depart Import any inj		21. Signature of Funeral Service Ucensee	M01148	22.	Name and Add Fink Fune	ress of Facility eral Home, Hwy S., (P.A. Hen Burni	e MD	21061			
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Ì	be executed sician and burial-transit	cal Exar	that initiated events c. — resulting in death) Last	Due to (or as a conseque	ence of):	· · · · · · · · · · · · · · · · · · ·							
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Box	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director. After this certificate has been signed by the attending physici sted filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 b No 4 9 ☐ Unknown 9	23d. Date of delivery Month Day Year									
ls, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contribut	ting to death but not resu	Iting in the ur	nderlying cause (given in Part I.			N 4	to the cause of death? Probably 4 Unknown		
Records,	hysician: The law req nis certificate has bee I director, page 2 shoi	Completed by						24a. Wa aut per	s an opsy formed?	24b. Were autopsy findings available prior to completion of cause of			
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of Vital	ding Physi h. After this o funeral dir	e: To	27. Manner of Death 28	1 Inpatient 2 E la. Date of injury 2	28b. Time of	28c. Inju	ıry at	Home 5 Res			ecify)		
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Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: A completed filled in by the f	al Cer	4 El Homide determined	e. Place of Injury - At hom building, etc. (Specify)				City or To	wn, Stat	e)	Rural Route Number,		
	he Hosi in 24 hc he Fune	Medical	29a. Certifier (Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Practice (Check 2 Certifying Nurse Practice)	the basis of examination :	and/or investig	gation, in my opir	ion, death occurre	d at the time, date	and place	e, and due to th	e cause(s) and manner stated.		
V	To t To t		29b. Signature and title of certifier	en w	>	29c. Licen	se number	54		ate signed (Mo			
		- 1	30. Name and address of person who complet Bahador Momeni, MD 86	,		,	11 W#11-	reville	МП	21100			
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re		TI MITTE	TPATTTE	, MD	21100			
	Registra	r	FEB 23 2010	Elevana	1 1	arkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Year Medical 4a. Facility Name_(if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Days, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 38 Director MARYLAND or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho, 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MDYes 2 No ems 23a or r must be r 10g. Citizen of What Country? Funeral W. FAYETTE STREET S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Examiner Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: BLACK Completed artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natui injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE MAINTENANCE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 KONALD EARL EGG 1E CRONDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EGGIE DAVIS (MOTHER PARKTON CT. BALTO, MDI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or oth 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 20/2010 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi e Linchsee SUGHN GKEENE FUNERAL M6 155 BACTO, MD, 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year ate has been signed by the a page 2 should be detached to 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an eral Director: After this certificate I filled in by the funeral director, page perform 2 🗌 No Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita မြ 1 Yes Other: Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural iniury 5 Pending Accident 3 Suicide Investigation 6 Could not be within 24 hours after d

To the Funeral Direct

completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Che Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only 29b. Sign License number Name and address of person who or leted cause of death (Item 23a) (Type, Print) Drae 2000 32. Registrar's State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#29d, perPHYS, G900, 2/23/2010, WS State of Maryland Department of Health and Mental Hygiene N5006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February **Physician** Day 2010 Bernard т. Elkins Sr. 4:50 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 675 Duvall Highway Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 219-28-7834 1932 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the findical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 675 Duvall Highway Funeral 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienw Important: If Item 27 is marked other tha any injury or other traumatic event, traupate. 6 Construction Bricklayer 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Furban Elkins Lovejoy Ella ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Elkins 675 Duvall Highway, Pasadena, MD 21122 (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 Cedar Hill Cemetery Baltimore, Maryland 21. Signature o Funeral Service Logise 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate performe 1 □Yes 20 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \(\sum \) Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 30. Name and add 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ARLOW -lora Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ESTMINSTER NING LENTER ARROLL 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 😿 F Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral ARRIC Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKEK HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SHOTTS ANCHE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRIEN BOLLINGER RD. WESTMINSTER, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plan Date 1 ☐ Burial 2. Cremation 3 ☐ Removal from State WINFIELD, MD ARROLL 23 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER 254 E. MAIN ESTMINSTER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Dec Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 EU MO 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DDA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Man r of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☑ Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number madles 0018 30. Name and address of person who completed caus se of death (Item 23a) (Type, Print) CUEDU 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Charles 1420 PM Eugene Flowers Jr. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07 02 Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 52 Months **X**☐M 2☐F 219-52-9514 57 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shevent, the tradical Evander rust be notified Director NA Baltimore 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1902 Altovista Ave 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>Ş</u> if Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade na Laborer Various Jobs 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles T. Flowers Mary Lou Dingle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and;
Department of Health
Important: If item 27
any injury or other tra Mary Walker-Sister 1902 Altovista Ave, Baltimore, ace of Disposition (Name of Date 20c. Location Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **※** Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/26/20 4 Donation 5 Dother (Specify) Woodlawn, Md 22. Name and Address of Facility
March F/H West Signature of Funeral Service Licens laulan 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sebsis 5day disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached I∏Yes 2∏No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical (Check only one) 29b. Signature and litle of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGNES

RIAZ

JAHAN

31. Date filed (Month

P24065

900 CATON ANE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Frances Eleanor Fisher 2010 8:40 pmM Feb. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home Prince Georges Charlotte Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔏 F 212-20-9621 Months 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Dundalk 1 🗆 Yes 2 🔀 No 10f. Zip Code 21222 10e. Street and Number 3106 Sollers Point Rd. 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 yrs. Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lottie Hattie Robb Charles Alexander Williams 19a. Informant's Name/Relationship (Type, Print)
Pat Oldewurtel daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1912 Holborn Rd. Dundalk Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State HOTY REDEEMED CEM. 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Feb. 18 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) Signature of June Service Licensee Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ARRHYTHMIA CARDIAC disease or condition resulting in death) Due to (or as a consequence of): ONGESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): STENOSIS HORTIC that initiated events Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent prednant 23d. Date of delivery Live Birth 2 Live Sirth 2 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 💋 Unknown KIDHEY 24b. Were autopsy findings available prior to completion of cause of death? DISEASE CHRONIC 24a. Was an autopsy performed'

26. Place of Death (Check only one)

28c. Injury at work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0067788

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

1 Tes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

12.2010

1 🗌 Yes 2 🗌 No

Ph sician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

မ

Md.

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Physician/Medical

Exami

IF FEMALE:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Completed by Be Certificate: To Medical

State

RAO 31. Date filed (Month, Day, Year) FEB 23 2010

29b. Signature and title of certifier

theenker

25. Was case referred to medical

2V No

5 Pending

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

examiner?

27. Manner of Death

1 Natural

Accident

3 Suicide 4 Homicide

29a. Certifier

(Check only one)

EENA



1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

28a. Date of injury

(Month, Day, Year)

28b. Time of

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 27, 2010 Flossie Fulghum 7:30 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Genesis Eldercare- Heritage Center Dundalk Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Davs Hours Min. July 17, 1918 Country) North **Director** 213-28-6059 Carolina Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21222 USA 3025 Liberty Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc 1 Never Married 2 Married Completed by 1 Yes : 21215-0036 1 ☐ Yes 2 X No Specify: White 3XXWidowed 4 □ Divorced Year or Dates al Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Floral Designer Florist 8 years marked other Be Page 1 and 2 should be filed ment of Health and Mental Hy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Mc Keel Allie Yelverton permit. Page 1 and 2 should Department of Health and Important: If item 27 is many injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Fulghum 3025 Liberty Parkway, Dundalk, Maryland 21222 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) February 1 Durial 2 X Cremation 3 DRemoval from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22, 2010 Signature of Funeral Service Licensee Connelly Fuheral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do bot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ORTIC disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner use as the burial-transi that initiated events attending physician and resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ā Hospital or Attending Physician: The law requires Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an has page 2 autopsy perform prior to completion of cause of death? After this certificate 1 Yes 2 No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending death. 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29d. Date signed (Month, Day, Year) WJULL MI)

State Registrar person who completed cause of death (Item 23a) (Type, Print)

2 Maxiel Place Dundale MD 21222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#15-17, 20a-c, 22per FH, 6900, 2726 / 2010, ws

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:04 PM vestertranklin Feb 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saltimore HOSP. TR Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 № M 2 🗆 F Months Days Hours Min (Month, Day, Director 212-40-0930 65 944 Maryland Usual Residence of Decedent or 28a-f show 10a State 10b. County ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 E. 25th St. 21218 USA death \ 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. "natural", or 2 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after Specify: black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation — G (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) unk 12th Odd Jobs unk Industry other traumatic event, Be 17. Father's Name (First, Middle, Last) -unk 18. Mother's Name (First, Middle, Maiden Surname) ည Roya1 Brown Ethel Noel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towanda Morton/daughter 2516 N. Ellimont Ave.; Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 6 injury (4 Donation a Dother (Specify) 2/23/2010 Ardent Crematory Hanover, MD None an Aldres of Ecolis Beverly D. Cromartie V/S 2/00 Edmondson Ave Baltimore, MD 2/223 Baltimore, Maryland 2/201 Signature Funeral Service Konald Director 221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Sause (Final Onset and Death Physician, Anoxic brain injur disease or condition day 5 Medical resulting in death) Due to (or as a consequence of): Examiner youndial 9 day 5 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine 100 Thermia executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical ospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No s after deau... ral Director. After this cerum...

1 in by the funeral director, pr 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined yithin 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) reb 66267 Name and address of person who cor pleted cause of death (Item 23a) (Type, Print) Hospital , 2000 W Battimore St. Battimore MD 21223 Bon Secours 31. Date filed (Month, Day, Year State Registrar FER 23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kevin Allen Fischer	1	- For State	State	of Maryla	nd / D		tment of			d Mental	Hyg		eg. No.	20	0	05012
Physician/		e gistrar I. Decedent's Name (First, M	iddle,Last	1)								Date of Dea Month		Year		3. Time of Death
Medical Examine		Kevin Allen										February	15, 20	. County of		2320 hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7 Misty Wood Circle #B 4c. County of Death Lutherville Timonium Baltimore County												nty		
Funeral		5. Social Security Number	6. Se	ex T	7. Age (Ir	n yrs. las	st birthday)	If Unde	If Under 1 Year If Under 24Hrs.			8. Date of Bi	rth (MM/	DD/YYYY)	9. Birth	place (State or Foreign
Director	Т	87-50-3099	1[X	M 2 F		53	Yrs	Month	s Days	Hours	Min.	Dec.	15,	1956	Cou	PA
	_	Jsual Residence of Deceder								<u> </u>						
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s after de real", or niner m		3 Widowed 4 X	Divorced	If Yes, Give Year		NO	1	Yes 2	X No	specify:				Specify:	Wh	ite
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36 in 72 h nan "r lical E	2	Elementary/Secondary (0-	12)	College (1 4 yea			Маг	nagei						Rest	taur	ant
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu c event, the Medical Exa	<u>.</u>	17. Father's Name (First, Mic	Idle, Last)		113		114			18.Mother's N	ame (F	irst, Middle,	Maiden			
215. be filed and Hy with the officers, the ent, the Be C	ĸl.	Ralph Fische	r							Donna	Lar	ne				
21; tould by Men ould by Men o	2	19a. Informant's Name/Relat	ionship (T		ormen	r		•		t and Number						Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be motified at once. To Be Completed by Funeral Director		Melissa G. F	ische	er Sp	pouse		18 Ad lace of Dispos			t. Reis		rstown Date				own, State
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr		20a. Method of Disposition 1 Burial 2 X Crema	ation 3	Removal fro	om State	cr	rematory or ot	her place)						•	
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Bal permi Depar Impo injur	ľ	21. Significance of Fundial Seri		Wayne	Octo	arli				tersto		NE FUN Rd. Re				MD 21136
Physician	7	23a. Part I. Erite the diseas	, or comp	lications that ca	aused the	e death.	Do not enter t	he mode	of dying,	such as cardi	ac or re	espiratory ar	rest, she	ock, or hea	rt	Approximate Interval Between Onset and
/Medical C	\downarrow	failure. List only one ca Immediate Cause (Final disc		Gastrointes	stinal H	emorrl	hage									Death
Zammer		or condition resulting in deal	-	Due to (or as a Chronic Alc):									
ā	5	Sequentially list conditions, if any, leading to immediate		Due to (or as a):									
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cox 68760 eath certificate b attending physi for use as the busical Medician/Medicia	֓֟֟֓֟֓֟֟֓֟֓֟֓֟֓֓֓֟֟֓֓֟֟֓֓֟֟֓֓֟֟֓֓֟֟֓֓֟	23b. Was decedent pregnant past 12 months?	iii tile	1 Live b	oirth nant at tim	ne of dea	- =	etal death ther (Spe	3 [c <i>ifv</i>)	Ectopic pr	egnand	СУ		Month	D	ay Year
Box e death c e death c the atten ed for us		1 Yes 2 No 9	Unknown		own		□ 0	mer (ope								
P.O. Be es that the de igned by the be detached if hy Phy		Part II. Other significant co	nditions	contributing to	death bu	ut not re	sulting in the	underlying	cause g	jiven in Part I.	•					he cause of death? ably 4 Unknown
S, P.C. uires that n signed d be deta										 	_	24a. Was				opsy findings available
Records, The law requires ficate has been sig page 2 should be	ble							_			-	auto		Р		ompletion of cause of
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on On O on on and ing ant he fun he f		1 🗸 Natural 5	Pending		n, Day,Year)			1 \	res 2 No						
Division of Vital Records, rat or Attending Physician: The law requirers after death al Director: After this certificate has been siled in by the funeral director, page 2 should bartification: To Re Completed	2		Investigat Could not	28e Plac	e of Injury	y - At ho	me, farm, stre	et, factor	, office b	uilding, etc.	2	8f. Location or Town,		and Numbe	r or Ru	al Route Number, City
Division o' Hospital or Attending 24 hours after death Funeral Director: After	֚֓֞֟֓֓֓֓֓֟֓֓֓֓֓֓֓֓֟֓֓֓֓֟֓֓֓֓֓֓֟֓֓֓֓֓֟֓֓֓֓֡֓֡֓֡֓֡֓֡֓֡֓֡֓֡֡֡֡֡	4 Homicide	determine	d (Specify)												
동조료의 등		29a. Certifier 1 Certifyir (Check onl) 2 Medical	ng Physic Examine	ian: To the bes	of examin	nowledg nation ar	je, death occu nd/or investiga	rred at th	e time, da y opinion	ate and place , death occur	, and di red at t	ue to the cau the time, date	use(s) a e and pl	nd manner ace, and d	as state ue to the	ed. e cause(s)
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カノ	1	30. Name and address of pe														
		Laron Locke MD.		tant Medica				n Stree	t, Baltir	more, MD	2120	1		_		
Stat Registra	te ar	31. Date filed (Month, Day, Y	2010	32. R	egistrar's	Signatu	Te Books									

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:25 PM accob Green 02 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NUrsina Catronsville Baltimore Haven Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

JUNE 28 9. Birthplace (State or Foreign South Carolina 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 □ F 07 086-12-887+ Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifiled at 1 Yes 2 No Director Timore 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 No If Yes, Give 12 1941 -Year or Dates: 8 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Let 15-0036

Let 1215-0036

Department of Health and Mental Hygiene.
Important: If Item 27 is marked other any injury or other terms. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify \$ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner Janitoria 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be iver ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daugther 905 Fordwood Circle Balto Hard 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of 21. Signature of Funeral Service Licensee no. Bala Fred Hillon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Demontra Vascular /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 KNo ို 2 ER/Outpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1. Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47683 2/22/10 mard Mille 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymand Miller 2835 Smith Ave Sime 203 Ra 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ODIGINIA

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 312 Per ANA BD G900 2/23/2010 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** 2010 5:58 Рм Francis Green /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 827 Arlington Avenue; #1016 Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number unk 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) unk **Funeral** Days Min. Months Hours 78 June 1, Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show Baltimore Director Baltimore 1 DXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 827 Arlington Ave; #1016 Funeral 21217 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1953 1 Mayes 2 □ No If Yes, Give 1958 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status unk Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 No Specify 2 3 Widowed 4 Divorced Ye ar or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation $\, {
m unk} \,$ 16b. Kind of Business/Industry unk permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the "Mode. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Dix/nephew 2230 W. Fayette St.; Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 21. Signatule of Funeral St. vice Licensee Ronal of Marie, 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or c not ion resulting in death) **Physician** ongestive /Medical Due to (or s a consequence of : Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year Day 5 ☐ Other (specify) signed by the a d be detached f 0 ☐Yes 2☐No 9 Unknown 9 Unknown σ. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t 24a. Was an autopsy performed? Yes 20 No certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: this ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural 2 Accident 28b. Time of 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated

DHMH 17 Rev 1/2001

State Registrar BALTIMOXE

address of person who completed cause of death (Item 23a) (Type, Print)

KIWAL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1/28/2010 Physician/ WILSON LEE GARRETT 130 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 8/10/194 Months Days Hours Min. Director 577**~**54**-**9664 68 Washington, Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No Maryland Prince George's Temple Hills 10e. Street and Numbe 10g. Citizen of What Country? Funeral 3107 Goodhope Ave. 20748 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" 3 Divorced 4 Divorced Year or Dates th and Mental Hygiene.

27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Locksmith Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked or
any injury or other traumatic ewe ပ Mae Thomas Henry Columbus Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fort Washington, MD 20744 1188 Windemere Court <u> Alberta Garrett / Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/16/2010 Cheltenham, Maryland <u>Maryland Veterans</u> Signature of Funeral Service Lensee 22. Name and Address of Facilit Pope Funeral Homes, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examir signed by the attending physician and d be detached for use as the burial-transit Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 winknown s been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manper of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🚅 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 7600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Padma Chirumamilla

MD

Carroll Ave. Takoma Park, Maryland 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death **Physician** /Medical (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Silver Spring If Under 1 Year 8. Date of Birth Month, Pay, Ye 12/03/1926 5. Social Security Number Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1□ M 2XF 577-40-5189 83 Yrs. Director Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at \mathbb{C} Director Washington 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3101 P Street, S.E. 20019 or Itema 23a USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Completed by Specify: Black 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Computer Specialist Fed. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard A. Hall Mary Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any njury or other training. Margaret C. Graham - Sister 504 Capitol Heights Blvd; Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 02/20/2010 ^¹ 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland 22. Name and Address of Facility Freeman Funeral Services e of Funeral Service Licens 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit 8 Due to (or as a consequence of): Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo in the past 12 months2 Day 5 Other (specify) P.O. | the 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 🗆 Yes 2 DN 1 Tyes 2 1 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🕒 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number Celen, M1,7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CREORGIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav ireen dna 2/15/2010 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9018 Cherry Lane South Upper Marlboro Prince George's 8. Date of Birth (Month, Day, Year 7. Age (In vrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Days Hours 96 Yrs. **Director** 215-20-3537 Meadows Usual Residence of Decedent or 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Maryland Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20774 9018 Cherry Lane South 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examone. 1 ☐ Yes 2 X No Specify: Specify: Black 3 → Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government <u>aborer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Hawkins Carrie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9018 Cherry Lane South Upper Marlboro MD. 20774 <u> Edna Douglas / Daughter</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 01ivet Mt 2/20/2010 | Washington, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes, P.A. M00981 5538 Marlboro Pike Forestville, Maryland 23a. Part 1. Enter the disease, of complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ atheroscleration cerebrovascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transi or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year the should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 025001 hypernan m

State Registrar

31. Date filed (Month, Day, 32. Registrar's Signature

705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ORIGINAL

DIGITAL

MD 21090

LINTHICUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b,c,perFH,G900,2/23/2010,WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dav Physician 11:30pM Elizabeth Powell Green 13 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Good Samaritan Nursing Center Baltimore
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 ☐ M 2 🕱 F Yrs. 226-48-3790 74 08/20/1935 Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1601 East Belvedere 21239 U - S - A -14. Race - American Indian, Black, White, etc. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales N/A 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown ျ <u>Anna Mae Foster</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Jackson (Daughter) 402 Grayslake Way, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Zion Community Cem.

Mt.Zion Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/19/10 Emporia, VA
Baltimere, MD 21. Signature of Funeral Service Licensia Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Medical Certification: To Be Completed

The law requires that the death certificate be executed P.O. Box 68760, the f atter for u signed by the a d be detached f Division of Vital Records, Attending Physician: director, After the funeral death. the efter deatl

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Pages 1 and 2 should be filed within 72 hours after death

Mental

item 27

Depertment of Important: If any injury or page.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

						1 Yes 2 No 3 Probably 4 Onk						
					_	24a. Was an autopsy performed? 1 Yes 2 1 No 24b. Were autopsy findir prior to completion death? 1 Yes 2 No 1 Yes 2 No						
25. Was case referred to medical examiner?				26. Place of	of Death (C	Check only one)						
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 (sing Home	forme 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 Adural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work?		28d. Describe how injury occurred						
3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street,	281	28f. Location (Street and Number or Rural Route Number, City or Town, State)								

29b. Signature and title of certifier

29a. Certifier

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number
058570 February 13, 2010

Loch Raven Blad Bultimere

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rance L. Beller MD 5601

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician /Medical 4a. Facility Name (If not institution, give street Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited any Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other traumatic event, in "Natical Exercited and Injury or other events." 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location by Funeral Director 1 Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ecedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry ngary (0-12) College (1-4or 5+) ma 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place ceme Method of Disposition ☑Burial 2 ☐ Cremation 3 Removal from State Burial 2 Dominion 5 Other (Specify) 1015. or complications that caused the death. ist only one cause od each line. 23a. Part 1. Enter the disea e shock, or heart failure. L Approximate Interval Between Onset and Death List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 \sum Nursing Home 1∐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Year 5 Pending 1 1 ☐ Yes 2 🗆 No investigation within 24 hours after dear To the Funeral Director completely filled in by the 6 ☐ Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of

31. Date filed (Month

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15^{Day} Month 02 2010 Clifton Ellwood Gould 8:35A Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Joseph Ritchie</u> Baltimore Hospice 5. Social Security Number b. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days 1 ፟፟ M 2 □ F **Director** Yrs 215-20-4747 81 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4803 Tamarind Road 21209 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3X Widowed 4 □ Divorced Black Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) years Carpenter Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellwood Gould Geneva Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 slument of Health a tant; If item 27 l Cheryl Gould(Daughter) 4713 Williston St., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important; If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Croahers Cemetery 02/22/10 Greensboro, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
JOSEPH H Fulton Ave., Funeral Home
2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician/ Septiz disease or condition resulting in death) hours Medical Due to (or as a consequence of) **Examiner** week Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Pars Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical YEE. 15 IF FEMALE: f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Director: After this certificate 2 🗌 No 1 Tyes Yes of Vital the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Haze 2 No Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) February 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balton Suite 2300 5200 Easton Ave MFLBIAG RachelB. Levine JHBVIC MD 21224 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:46 P M 2010 Dorothy Lee Goldberg January 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Trappe Talbot 1851 Ocan Gateway 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min. 1 □ M 2 🗗 F Months Days Jan 1, 83 1927 0klahoma 445-22-8068 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 1 ☐ Yes 2 🖾 No Director MD Talbot Trappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21673 1851 Ocean Gateway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married white 1 ☐Yes 2 No <u>۾</u> Specify Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) restaurant business waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Edward Meadows Myrtle Lou Alexander ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1851 Ocean Gateway; Trappe, MD 21673 Cheryn Sinor/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4K Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade ^{22. Name and Address of Facility} State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Iman 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 2 **N**O 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide

Box 68760, P.O. Records, of Vital

requires that the death certificate be executed Division Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft

Examiner

Funeral

Director

28a-f show

r items 23a or 28a-f shov

2 should be filed within 72 hours after death with in and Mental Hygiene.

Is marked other than "natural", or items 23a or

Health tem 27 I

permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once.

Physician /Medical

Examiner

burial-trans and

attending physician for use as the buria

signed by t

certificate

After this

other traumatic event, the involcal Evan

Baltimore, Maryland 21215-0036

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's

29a. Certifier

DHMH 17 Rev 1/2001

MD

1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 7-12-10

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year)

FEB 23

00:6

2010

FEBRUARY

GOMPERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ arout Pencer 2100 PM 02 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical ('enter MO Anne Arundel Annarl Annapolis If Under 1 Year If Under 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) unk **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Jan 6, 1926 213-82-0784 Director 84 Usual Residence of Decedent 28a-f shov 10a. State within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crownsville 1 🗌 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1454 Fairfield Luke Rd. 21032 12. Was Decedent Ever in U.Sunk 11. Marital Status unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin \$ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Un-(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry un (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Arundel Med Ctr/hospital 2001 Medical Pkwy; Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other Specify) in State cemetery, crematory or other place Signature f Funeral Service Licensee State Anatomy Board; 655 W. Baltimore Street Director 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician enumonia disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and -transit Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗷 No မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. М ☐ Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueau occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 069566 2/14/10 Ch

Registrar
DHMH 17 Rev 7/2009

State

Parkway

Annapolis

MD 21401

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2001

Michel

TVCISSE M 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #17 per Fh g900 2/25/10 IT.
State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 21, 2010 **Physician** Dorothy B. Huston **12:57 p**^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Sept. 19,1936 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Maryland 7. Age (In yrs. last birthday) **Funeral** Days Hours 215-34-4926 1 ☐ M 2 🕱 F 73 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprainment must be notified at Maryland Anne Arundel Annapolis 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 115 East Lake Drive 21403 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Brampton Bampton Audrell Winters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 East Lake Drive Annapolis, Maryland 21403 John W. Huston, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Irc. 10l Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VIV disease or condition resulting in death) 0 cordin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 📮 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after deam.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2-21-2010 02804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annopolis MD 21401 chort T relesson 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Montal Hygiene Certificate of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Itildert Februaru ZOIO 1:40pm racuret Medical 4a. Facility Name of not institution give street and number)
JOHNS HOKINS BRYVIEW MEDICAL CENTER
49140 Eastern Avenue Baltimore Miryland 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Caltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕮 F De Cont Oay, Year 30 North Carolina 240-34-1355 79 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 K No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21228 711 Maiden Choice Ln. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 _{Specify:} white 1 ☐ Yes 2🎛 No Specify: 3 x Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ dietary aide nutrition Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larry Brynt Britt Irena Victoria Baxley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1015~{
m Hewitt~Way;~Baltimore,~Maryland~21205}$ Greta McClaskey/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funery & rvice Licensee State Anatomy Board; 655 W. Baltimore Street Baltimore. Maryland 21201 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death Physician/ ardiopulmonary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner cemia 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi SION Due to or a a managuence of: resulting in death) Last Physician/Medical mia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 No Leen signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icale has been sig ; page 2 should b Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificale 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 X Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After t
completed filled in by the funera 1 🗶 Natural 5 \square Pending 1 🗌 Yes 2 🗌 No 2 Acciden
3 Suicide Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20676 wegary 30. Name and address of person who completed cause of death (Item 23a) (Typ Eastern Avenue 31. Date filed (Month, Day, Year) **FEB 2 3 201**0 Registrar's Signa

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05026 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 2010 Virgie I. Hedges 6:12a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminister Carroll If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Sept Day 8 1 191 Hours 1 M 2 XF MD 212-01-7274 95 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene.

Jother than "natural", or items 23a or 28a-f sho iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Carroll MD Westminister 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 27 Washington Lane 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Completed 3 X Widowed 4 Divorced White other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Box Maker Gordon Box Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Jacob Streib Pearle Adams and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trae James Hedges III /son 203 Antietam Road Baltimore MD 21221 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Glen Haven Memorial 2/24/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) June of Funeral Service Licer 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or compl cation, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 4 9 Unknown signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INSUFFICIENC 2 WNo 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requi within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 25. Was case referred to, medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital ٥ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending Natural M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) WEST MINSTER MIS

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Amend PI line b per ME & 25 per ME 9901 374/10 TT State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day - Month Year **Physician** Raymond 17,2010 Hill rebruary /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Year If Under 24 Hrs. 8. Day of Birth (Month, Day, Year) Baltimore nousyland Greneral Birthplace (State or Foreign Country) **Funeral** Days Months 214-44-7887 65 Director 1-15-1945 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 XYes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must to 1102 W. Mosher Street 21217 S Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Itimore, Maryland 21215-0036 Black Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 2nd_grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura Johnson Preston Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Cooper- Fiance 1102 W.Mosher Street Balto, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt Zion Cemetery 2-23-2010 Lansdown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Foreral Service 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner NCONTROLLED HYVER TEUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed DRUG ABUSE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2X1 Medical Certification: To 2 KER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of coffifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 LINDENAVE, BALTIMORE, MD, 2120 LOMKIN, MD 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2 HART Physician INEZ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRIVLE GEORGE'S CRESCENT RIVERDALE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 😾 F **Director** 577-24-9875 95 7/23/1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 Varney Street SE # 002 20032 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: 2 Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tom Henry Dabney Agnes Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Glivings / Grand Daughter 644 Brandywine Street SE Washington, DC 20032 other permit. Pages 1 and Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2/18/2010 Harmony Memorial Landover, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signatur of Funeral Service Lice M01055 5538 Marlboro Pike Forestville, Maryland 20747 23a. Par 1 Ther the disease in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate Cause (Final Physician CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of):

Approximate Interval Between Onset and Death MONTHS

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 Ectopic pregnancy

23d. Date of delivery Month

Year

2010

2:10 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 □Yes 2 □ No

Goochland, VA

Black

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy nerformed' 1 ☐ Yes 2 1No 24b. Were autopsy findings available prior to completion of cause of death? 2 □No

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be

determined

and manner stated

28b. Time of

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

KIVELDALE,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title MD 29c. License number D-29514 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIMME2 HLLEN M.D 4409 EAST-WEST HIGHWAY

31. Date filed (Month, Day,

IF FEMALE:

Completed by

Be

Medical Certification: To

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☑ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

3 ☐ Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature



DHMH 17 Rev 1/2001

P.O. Box 68760,

ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burish-transit

Division of Vital Records,

To the Hospital within 24 hours a To the Funeral D

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1610 PM **Physician** HARRELL 26 10 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bon Secoves. BALTIMORE N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/13/1961 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🔀 F 220-64-3663 68 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner traust be profifted at 1 XYes 2 ☐ No Director N/A MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2306 Winchester Street Apt.B 21216 .S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ∑XNo If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ۾ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Laborer Stadium 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be N/ANoble Margaret ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health s permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. Vanessa Green(Cousin) 2306 Winchester Street, Baltimore, MD 21216 20b. Place of Disposition (Name of Joseph Brown F/H And Crematory 20c. Location - City of 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 02/20/10 Baltimore, MD Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee Mamo 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sersis DAYS **Physician** /Medical Due to (or as a consequence of): Examiner RESPIRATURY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐Yes 2 ☐No 1 🗌 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral (28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE ere Marcolini 2000 31. Date filed (Month, Day, Year) Registrar's Signa State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 18,2010 2:03 Рм February Thelma Elizabeth Harthausen 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1334 Old Fieldpoint Road Elkton Cecil 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 17, 1919 9. Birthplace (State or Foreign Months Days Hours Min. Maryland 1 □ M 2 🗓 F 218-01-1411 90 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c City Town or Location Parkville 1 □Yes 2 □XNo Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21234 2620 Windsor Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2X No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.White 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Brager Company Elementary/Secondary (0-12) College (1-4or 5+) Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Christine Rittershofer Joseph A. Miles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1819 Glendale Lane-Bel Air, Maryland 21015 Linda Depasquale-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1-eb 22,2010 21. Signerure of Funeral Service Licensee 22. Name and Address of Facility VIS Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 andra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ORONARY)155 ASE .. disease or condition resulting in death) Due to (or as a consequence of): COLON MANE Yus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 moulls ANEMIA Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an Was autopsy performed? 1 ☐ Yes 27. M

Physiclan: The law requires that the death certificate be executed and burial-P.O. Box 68760. attending physician for use as the buria signed by the a Division of Vital Records, has page 2 s certificate director, this After this funeral of ne Hospital or Attending Pl n 24 hours after death. The Funeral Director: After the funeral oletely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Certification: To

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?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, III

Physician

/Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0036

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case refer	red to medical	26. Place of Death (Check only one)											
examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 🗈	OOA Other:	4 🗆 Nursing Ho	ome 5 Residence	6 Other (Speedly)					
27. Manner of Deatl 1 ☑ Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work?		28d. Describe how inj						
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, stree fy)	t, facto	ry, office	28f. Location (Street and Number or Rural Route Numb City or Town, State)							
29a. Certifier	1 Certifying Ph	ysician: To the best of my kno	owledge, death o	occurre	d at the time,	date and place	and due to the cause	(s) and manner as stated.					

one) and manner stated. 29b. Signature and title of dertifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d, Date signed (Month, Day, Year)

D22652

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. S. SRINIVAS

(Check only

RALTIMORE

MD 21239

State Registrar

completely

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To the l within 2. To the l

31. Date filed (Month, Day, Year)

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(Examin		4a. Facility Name (if not institution, give street	and number)		120001	Location of Death		Ba /	
		Funeral Director		5. Social Security Number 6.5 x 1 M	7. Age (In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	1916	9. Birthplace (State or Foreign Country)
		*	,	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation		0-7	1910	10d. Inside City Limits
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		with the s 23a or ust be r	Funeral Director	10e. Street and Number 3947 Cartha	se Road	,	10f. Zip Code	1/33		10g. Citizen of W	hat Country?
	(0	s after death witl ral", or items 23 Examiner must	by Fun	11. Marital Status 12. V	us Decedent Ever in U.S med Forces? Yes 2 No	3. 13.	Was Decedent of H f Yes, specify Cuba		ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
	-003	2 hours aftu "natural", edical Exar	eted k	2 Windows 4 D Dimension If	Yes, Give ear or Dates.		1 ☐ Yes 2 ☑ No dent's Usual Occup			Specify:	Black
	1215	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	(Specify only highest grade co	mpleted) ollege (1-4 or 5+)	(Give life. D	kind of work done o O NOT use retired)	during most of work)	16b. Kind of Bus	siness Industry
	nd 2	ert Fed	To Be (17. Father's Name (First, Middle, Last)	1	Licer	1340	18. Mother's Nam	.,,	Maiden Surname)	Care
	Maryland 21215-0036	1 and 2 should be file if Health and Mental item 27 is marked of other traumatic eve	-	Glamanda Si 19a Informant's Name/Relationship (Type, Pr		19b. Mailir	ng Address (Street	Mari and Number or Rui		GY ; City or Town, Sta	ate, Zip Code)
		and 2 s Health a tem 27 i		Charlene Hari		394	17 Car7	Hage 1	Road Date	Randa	//s/fown M 2/13
	altimore,	0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		onetery, crer	natory or other place a Wn		4-2010		more mb
	Bal	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licensee	Grune	22	728 Li	ss of Facility Vau	ghn C.6	1 1/ /	uneral Services Un.MD 21133
3				23a. Part 1. Enter the disease, or complicatic shock, or heart failure. List only one cau Immediate Cause (Final	ons that caused the death se on each line.	n. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arm		Approximate Interval Between Onset and Death
0		Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	ence of):	MAK	< >	リヒド	ENT	A Chiece and Beauti
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12/20	× 687	th certific tending or use as	Physician/Medical	200. Was decedent pregnant	yes, outcome of pregnar Live Birth 2 □ Feta	Ideath 3 🛚		y		4	of delivery
77	O. Box	the deal by the at ached fo	hysic		☐ Pregnant at time of d ☐ Unknown	eath 5 L	Other (specify)			Mont	th Day Year
Z	s, P.(I law requires that the death certificate be executed has been signed by the attending physician and je 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributions CEREBRA	LVASO	2021	7R/h	en in Part I.	23e. Did to	• /	oute to the cause of death?
Arvi	×	law requas beer 2 Shou	Completed by	BREAST	CAN	CER	2		24a. Was a	sy pri	ere autopsy findings available for to completion of cause of
土	al Re	ian; The rtificate l	Be Cor	25. Was case referred to medical			26. Pla	ace of Death (Chec	perfor 1 \sum Yes k only one)		eath? Yes 2 No
م	of Vital	y Physici er this ce eral direc	은	examiner? 1 Yes 2 No Hospit 27. Manner of Death 28	1 Inpatient 2 Ba. Date of injury	28b. Time of	othe	4 □ Nursing H		ence 6 Other	
Fry	Division of	ttending death. tor: Afte the fun	Certificate:	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1 □	? Yes 2 □ No			
	Divis	ital or A urs after ral Direc lled in by	al Cer	4 - Hornicide determined	e. Place of Injury - At hos building, etc. (Specify)				City or Town	n, State)	or Rural Route Number,
		To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 Medical Examiner: O	To the best of my know on the basis of examina of	and/ in est	igation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due t	o the cause(s) and manner stated.
4		Vith Con.		29b. Signature and tiple of certifier	nach	1	29c. License	number A 49	569	29d. Date signed (Month, Day, Year)
•		11/		30. Name a a dryss of person w o comple				- MD 01	206	Mac	
		Stat		Alan M. Shorofsky, M. 31. Date filed (Month, Day, Year)	32. Rugistrar's Signat	ure _	ve Towso	on, MD 21	<u> </u>		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11tems 23d,25,27,28a-f per me g919 9-26-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 177H 2010 **Physician** 11:05 AM FEB Johns Janney Hoffman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Months Days Hours Min. Director 212-20-3176 Oct.18. 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the No Jick Examinating be notified at Director 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Taplow Road 21212 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 No life yes 2 No life yes, Give 1950 - 1952 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Systems Engineer <u>Not Available</u> pernit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Johns Hoffman Margaret Osburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 McKinley Street Washington, D.C. Mary Ryan Conroy Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2-22-2010 Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland 21204 Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATIO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ENSORIUM IMINSHED Sequentially list could not if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be execute ELIRIUM sician and burial-tran Due to (or as a consequence of) physician the burial Box 68760 Physician/Medical Hip Fracture with Complications attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital 1□Yes 2□No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 □Yes 2 No 24 hours after death. Funeral Director: / 2 XAccident investigation Feb. 10, 2010 Unknown subject slipped and fell filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 314 Taplow Rd. 4 Homicide home Baltimore, Md. Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD0066369 Cun 20010 dry arikers 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PRIYANKA SOIN 5601, LOCH RAVEN BLVD, BALTIMORE, MD 212 3 9 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

HOFFMAN

10-01503 Kristoffer Hjelle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25 Tate of Waryland / Department of Health and Mental Hygiene

stoffer Hjelle		amend #2State of Waryland / fo	epartment of Certificate of		and Mei			20 l	0 05033			
Physic	ian/	Registrar 1. Decedent's Name (First, Middle,Last)				2	2. Date of Dea	Say Year	3. Time of Death			
dical Exam	iner	Kristoffer Hjelle					February	18, 2010 4c. County of Deat	0920 hrs			
		Facility Name (if not institution, give street and number) University Hospital	4	Baltimor	n, or Location e	n of Death		Baltimon				
			yrs. last birthday)	If Under 1		der 24Hrs.	8. Date of Bir	th(MM/DD/YYYY) 9. Bi				
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D 2. should and M 7 is m.	욘	19a. Informant's Name/Relationship (Type, Print)			is Run			06001	e, zip code)			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any ining yor other remuratic event, the Medical Examiner must be notified at once.		Steinar Hjelle / father 20a Method of Disposition	20b. Place of Disposi	tion (Name		AVOI	Date	20c. Location - City o	r Town, State			
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the Hos nin 24 ho the Fun	edical	one) 2 Medical Examiner: On the basis of examinar	iowiedge, death occur ation and/or investigat	tion, in my o	pinion, death	occurred a	t the time, date	e and place, and due to	the cause(s)			
To the within 7 To the	Med	and manner stated. 29b. Signature and title of certifier			icense numb			29d Date signed (M				
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		30. Name and address of person who completed cause of leat	h (Item 23a)	<u>' </u>								
		Theodore M. King, Jr., MD. Assistant Med	ical Examiner		n Street, E	3altimore	e, MD 2120	11				
Regi	State	31 Date filed (Marth Day, Xear) 2010 32 Registrar's S	Signature Some	Kal								

DHMH 17 Rev 1/2001 OCME 2006 10-00832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11, 13 tale of Maryland? Department of Health and Mental Hygiene Toni Harris 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1311 hrs January 29, 2010 **Medical Examiner** Toni Harris 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery 9711 Saxony Road Silver Spring If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State ounk 5. Social Security Numbernk 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours Min July 2, 1975 Director 34 Country) 2 X F M Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location Ę 10a State 10b County Yes 2 X No MD Silver Spring Montgomery Pages I and 2 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland net of Health and Mental Hygiene.
If litem 27 is marked other than "nature!" narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9711 Saxony Rd. 20901 USA 11. Marital Status unk 12. Was Decedent Everity U.S. Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X No Yes 4 X Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: White 3 Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 11716 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Restaurant Buisness unk unk Waitress 18.Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) tink Be David Robert Harris 19a. Informant's Name/Relationship (Type, Print)

Karen Graves/friend 19b Mailing Address (Street and Number of Rural Route Number Cinn T21409 Zip Code)
111 Penn Street; Baltimore, Maryland 21201 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Department or Important: I Dongtion & K Other Specify: in state Funeral Service Licensee Ronald, SAMAN 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Director The disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and List only one cause on each line /Medical Death a Narcotic (morphine) & aminoclonazepam intoxication Immediate bause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for as a consuduring off if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical AMENDED 23a,27,28a-f,permE, g902 4/2/10 TT X UNPENDED attending physician or use as the bunal P.O. Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown signed by the a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed' death? 1 🗸 Yes certificate page ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Other: Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes No After Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 1 Yes 2 X No Pending death. Director: the Fd 1/29/10 Fd 1:00 pm 2 Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 6 X Could not be 3 Suicide 9711 Saxony Rd Silver Spring, MD determined House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified January 30, 2010 O.C.M.E. 200 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Margarita Korell MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signa State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, I'm I'matural", or items the result in the I'matural in I'matural I'matural in I'matural in I'matural in I'matural in I'matural I'matur	9000
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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DHMH 17 Rev 1/2001

		For	State of Marylan				d Mental Hy	giene		
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/Med	ical	KOBER + 4a. Facility Name (If not institution, give st	reat and number)	176	4b. City, Town, or		[Fe3hUA		4 2010 County of Death	J.13™
Exam	iner	The Johns Hopkins Hos	spital		Baltimore	City	٠		·	
Funeral Director		5. Social Security Number 6. Sex 214-39-5248	7. Age (In yrs.		If Under 1 Year Months Days	Hours N	Hrs. 8. Date of Bir (Month, Da May	th 27, 27,	Counti	ace (State or Foreign ry) ryland
and	٦.	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ation				10	0d. Inside City Limits
death with the Maryland ems 23a or 28a-f show must be notified at	ō	MD Harford		Street						1 ☐ Yes 2 XNo
r 28a notifi	Director	10e. Street and Number			10f. Zip-Code			10g. Citiz	en of What Count	ry?
th with		4515 Oak Ridge D:	rive		2115	4		U	nited St	ates
r deal	Funeral	TTT Wantar Olatas	Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hi	ispanic Origin' n. Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	. 1	14. Race - America Black, White, e	
DESILIMOTE, INIGITISING 21215-UU36 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylann Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		☐ Yes 2 No	Specify:	,		0	White
5-0036 72 hours aft natural", or dical Examir	ted	15. Decedent's Educ	ation		ent's Usual Occup			16b. Kii	nd of Business/Inc	
hin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		kind of work done of O NOT use retired,		working			
Valence the	Som	10	,	Stu	dent				/A	
//and	Be	17. Father's Name (First, Middle, Last) Robert Hairsine	Sr				Name (First, Middle ce Ann	, Maiden	Surname)	
rylo hould d Mer marke	2	19a. Informant's Name/Relationship (Type		19h Mailin	a Address (Street :		or Rural Route Numb	er City o	Town State Zin	Code)
Mal id 2 st ith and 1th and 27 is r traum	10.3	Alice Ann Fisher		Til			ive Stree	-		coue)
re, s 1 an f Heal ftem 2		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of	1	Data	200 100	cation - City or Tov	vn, State
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Dalti permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee	1 MO158	5 22	Nace and Arder	Shof Facility	Funeral Al	terna	tives	
o 99 = 8 9		Medocca Ha	cheman				ures Drive		on Maryla	and 21286
	l., ,	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ente	r the mode of dyin	g, such as car	rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_Acute M		nous L	eukem	iA			Onoce and Doddi
Examiner			Due to (or as a consequent	u de of): d						
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						
of oU , cate be executed physician and s the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
ate be e	edical	d.								
se as		IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna	incv					3d. Date of deliver	2,
that the death certificate by the attending pedetached for use as	Physician/M	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Feta 4 Pregnant at time of de		Ectopic pregnancy Other (specify)	′				Day Year
the d	hys	9 Unknown	9 Unknown							
S that	by F	Part II. Other significant conditions conti	ributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.			se contribute to th	
w requires that been signed to be de							_ 1 🗆	Yes 2	No 3 □ Proba	ably 4 🗌 Unknown
law nas be	Completed						24a. Was autor	SV	prior to con	sy findings available npletion of cause of
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Atter er dea ector; by th	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Number or Rural	Route Number,
tal or rs after all Dir	Cer			/			Ony 01 701	ri, otate)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2	edical		cian: To the best of my know er: On the basis of examinat and manner stated.							
To the within To the comple	Med	29b. Signature and title of certifier			29c. License	number		29d. Date	signed (Month, D	lay, Year)
		Matthew H. M	lemes MA		Rp.	5-00	00	-E12R	UARY 14	12nin
HI		30. Name and address of person who con		23a) (Type, I	Print)				,	•
./^		MATTHEW H ME	ERVES, MD			60	00 North Wo	Ife St	, Baltimore	e, MD, 21287
St: Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure Box	20					

DHMH 17 Rev 1/2001

		-	For State	State of Maryla		artment of H <i>tificate of D</i>			2111	0 05038
			Registrar 1. Decedent's Name (First, Middle, La	ist)		tilloate of E		2. Date of Death	eg. No. —	3. Time of Death
	Physicia Medic		Raymond Henry Ho	olter			Į	Month FEBRUAR	Day Year	010 06:00M
	Examin		4a. Facility Name (if not institution, giv		Jenter	4b. City, Town, or	Location of Death	son	4c. County of De	ath altimore
	Funeral		5. Social Security Number 6. 9	Sex 7. Age (In yr	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, June 29	Year)	Sirthplace (State or Foreign Country) Maryland
4.6	Director		705-09-0500 Usual Residence of Decedent	100) 113.			June 29	, 1909	Maryland
	show	tor	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-f otifie	irec	Maryland Baltin	more	White M					1 ☐ Yes 2 🏝 No
	th the	al D	10e, Street and Number	_		10f. Zip Code		1	0g. Citizen of What (Country?
	ath wi	Funeral Director	5907 Allender Ro	Dad 12. Was Decedent Ever in	118 13 1	21162	spanic Origin? (Spe	cify Yes or No-	USA	nerican Indian,
036	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show tie event, the Medical Examiner must be notified at.	by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
2-0	hour "natu dical	plet	15. Decedent's (Specify only highest g			dent's Usual Occupa	ation Juring most of worki	na	16b. Kind of Busines	s Industry
Maryland 21215-0036	rithin 72 iene. r than the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)	e Preside		Railroa	d
פ	filed val Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		laiden Surname)	
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Jar	shour and is is m		19a. Informant's Name/Relationship (Type, Print)		•			City or Town, State, a	
	e 1 and 2 should be filed with of Health and Mental Hygien If item 27 is marked other th r other traumatic event, the		Raymond H. Holte 20a. Method of Disposition		12819 b. Place of Dispo				yer, Flor 20c. Location - City	ida, 33912
nor	Page 1 ment of I ant: If it ury or o		1 X Burial 2 ☐ Cremation 3	Removal from State	cemetery, cren	natory or other plac	Cem. 2/24		Bradshaw,	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Spec						neral Hom	-
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	Medical Examiner		resulting in death)	Due to (or as a cons	. ,	RY DISE	OGF			
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as a cons	equence of):					
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3/60	ificate ig phy as the	Med	IE EEMALE.							
. Box 68	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ I 4 ☐ Pregnant at time g ☐ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of o Month	delivery Day Year
О	law requires that the nas been signed by the 2 should be detach	by	Part II. Other significant conditions SEVERE MITRA	9	o .	inderlying cause giv	ren in Part I.			to the cause of death?
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2	The law n cate has b page 2 st	Completed						24a. Was an autops: perform	y prior to ned? death	
ıta	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	□ 5 0 (0 ± ±	Othe	ace of Death (Checker:		<u></u>	
n of V	nding Phy th, After this funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 N Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury work	at :	me 5 ∐ Resider 28d. Describe hov	nce 6 Other (Sp. w injury occurred	ecify)
Division of	al or Atter s after des Il Director ed in by the	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Injuny - A		eet, factory, office		28f. Location (Str. City or Town,	eet and Number or F . State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examina rse Practioner: To the best o	ation and/or invest	tigation, in my opinic	n, death occurred at	the time, date and	d place, and due to th	e cause(s) and manner stated.
	To t		29b. Signature and title of certifier	P melt	a mit			29	9d. Date signed (Mor	nth, Day, Year)
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type, F		1410			, ,
	Stat	0	31. Date filed (Month, Day, Year)	32. Registrar's Sig	making A		RIVE TO	WSON, h	MARYLAND	21204
	Registra		FER 23 2010	Lenera B	. par					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Rosalie Edna Hall 10:15 PM 20, 2010 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examine Bel Air Harford Catered Living of Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🔀 F Director 89 17. 1920 Maryland 218-01-7653 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner hast be notified at 1 ☐ Yes 2 TXNo Director Maryland Harford Churchville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 72 hours after death with 3204 Whitefield Road 21028 USA Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married or. Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔯 No þ 3 XWidowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mas Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christina Edna Funk ဂ္ John Joseph Harr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly E. Brooks / Daughter 3204 Whitefield Road, Churchville, MD 21028 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Buria 🕴 2 🗆 Crem 4 □ Donation 5 □ Ottler (Specify) 2-27-10 Bel Air Memorial Gdn. Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 of Funera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final disease or condition resulting in death) scul **Physician** 2-4ETRS /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed sician and burial-tran Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Mo 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death Month Day Ye ar 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an cate has by page 2 s autopsy certificate 2 **1** No 1 TYes this certific al director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 ☐ Yes 2 🔽 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier

P.O. Records, Hospital or Attending Physician: The of Vital Division the

> State Registrar

(Check only one)

29b. Signature and title of certifier

FEC TO

DHMH 17 Rev 1/2001

and manner stated.

30. Name and address of person who completed cause of death (Item 25a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

- 1716 HAPPORD RASU 105 FACISTON HO 2104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year TRENE THELMA IMBRAGULIO **Physician** 5:05 PM FEBRUARY 18 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner N/a MORE HOSDITA HARDOR If Under 24 Hrs. 9. Birthplace (State or Foreign f Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Funeral Hours Maryland 1 □ M 2 🖵 F 84 213-20-9117 Director 11 - 2 - 1925Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State r items 23a or 28a-f show item oust be notified at 1 ☐ Yes 2 ☑ No Funeral Director Lansdowne MD Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 200 First Avenue 21227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ō Specify Specify: White 7 is marked other than "natural", o traumatic event, the Medical Even 2 3 ₩ Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Art Lithographs Book Binding 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Nelson Baker Hilda Kiel ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Delores Pappas - Sister 3215 Rosalie Rd., Lansdowne, MD 21227 item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 NBurial 2 Cremation 3 Removal from State 2-23-2010 Gedar Hill Cemetery : Brooklyn, MD 4 ☐ Quantion 5 ☐ Other (Specify) n re o Euperal Service Lines 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 days Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician s the burial-Box 68760, attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the a detached f signed t I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ DU MONAR) 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s perform certificate 1 ∏Yes 2. 1 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) ie Hospital or Attending Pl 24 hours after death. Ie Funeral Director; After the 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fi Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie RES 000 February, 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

FEB 23 2010

31. Date filed (Month, Day, Year)

NikitA Pozderev, MD. 3001 South Hanover Street, BAltiMore, MD, 21225 32. Registrar's Signature A. Sare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:45 PM Lois Marion Jones February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1607 Park Grov<u>e Avenue</u> Catonsville 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 24, 1921 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Illinois 88 Yrs Director 360-09-6968 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f shoramatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Catonsville Baltimore Maryland 10f. Zip Code Street and Number 10g. Citizen of What Country? Funeral 21228 USA 1607 Park Grove Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) +2 Elementary/Seconday (0-12) Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည age 1 and 2 should be int of Health and Ments it If item 27 is marked or other traumatic e John William Rea Stephanie Mary Hacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Park Grove Avenue Catonsville, Maryland 21228 Harold C. Jones, Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Metro Crematory Inc. | 02/19/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Name and Address of Society Of Maryland, Inc. 99 Frederick Road Baltimore, Maryland 21228 Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 12 a geors disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a sunsequence of) Exami Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown ed by the a detached f signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law After this certificate has funeral director, page 2 autopsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: ည 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work?
1 Yes 2 No death. n 24 hours after death.

e Funeral Director: A sleted filled in by the fu Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 🗆 only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 3 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 10710 Charter Drive Suite GO20 Columbia, Maryland 21044 B. Knight, Clement 31. Date filed (Month, Day, Year) State

Registrar

FEB 2

510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 **Physician** attle 11:20 AM -00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Agnes Baltimore HOSPITON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 M 93 214-58-6610 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 LaYes 2 □ No Director Marviara 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Newer Married 2 Married 2 N Baltimore, Maryland 21215-0036 1 □Yes 2 DMo 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. Do NOT use retired)

ReStaurantem 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Itattie Haustus ဂ္ဂ 19a. Informant's Name/Relationship (you. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. grand daught 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State ld. National Laurei 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S≢rvice License viand 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypercapruc day disease or condition resulting in death) /Medical as a consequence of): Due to (or Examiner whomas if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the Ö detached 9 Unknown law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an has autopsy performed? Yes 2 No Physician: The certificate 1 □Yes **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ M.D Malling 215+ 22257 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MALLIKA · ANGITIPALLI , ST Agnes Hosp Baltmore 900 S. caton Avenue Hospital,

Registrar

State

JACKSON

32. Registra Sign

MD

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** Johnson Donald 5: 22 PM /Medical 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) **Funeral** Days Months 100 M 2□ F Director Ne Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Be Completed by Funeral Director Maryland 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? items 23a or 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Hygiene. other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Norken other permit. Pages 1 and 2 should be file Department of Health end Mental Hy, Important: If item 27 is marked other any injury or other traumant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname epm JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) danable 4ressy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician Lung Can cer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Electronic injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after useum.

To the Funeral Director: After the Funeral Director of the funeral 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057465

Registrar DHMH 17 Rev 1/2001

State

32. Registrar Signa

N.S. Rajapakse

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapakse, M.D. 2835 Smith AV, 5-203, Baltimore, MD. 21209.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ Medical Facility Name (if not institution, Town, or Location of Death 4c. County of Death **Examiner** NWSING HOME TIMOVE 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Min. Country) **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10d. Inside City Limits 10a. State City Town or Location Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Completed by 21215-0036 1 ☐ Yes 2 📉 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life DD NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Be Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Pi 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 F Donation 5 Other (Specify) Removal from State 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line. Approximate Interval Between Jest Je Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 9 Unknown n signed by the a 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
Accident injury work 5 Pending 2 🗌 No 1 Yes Investigation Accident completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 158570 and address of person who completed cause of death (item 23a) (Type, Print) Jerra 31. Date filed (Month, Day Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:50 A.M. Lucille Johnson chrocon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day April 1 Days 1 □ M 2√2 F 219-34-0825 Director 72 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7004 Cresthaven Drive 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ☐ Yes 2 🖾 No 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. White Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life_DO NOT use retired) Home Maker (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0wn Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Harvey Tuckey Almira Dorina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Lewis Wayne Johnson/Husband 7004 Cresthaven Dr. Glen Burnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February cemetery, crematory or other place) 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State Atlantic Crematory 22, 2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Ave., SW Glen Burnie, MD Signature of Funeral Service Licens 21061 Singleton Funeral & Cremation Services PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) t (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events leaduance of or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending M 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 1🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2106/-

Registrar

State

State Registrar

31. Date filed (Month, Day, Year)

FEB 23 2010

P.O.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26, 28b of Marylang 901 3/19/10 TT ealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 20 2010 Day 11:35 PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Randallstown Baltimore S easons Hospice Northwest 8. Date of Birth (Month, Day, Year)
May 9, 1924 9. Birthplace (State or Foreign Country) VA Days 1**∑** M 2□ F 85 578-20-9433 Yrs May Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD 1 □Yes 2 No Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 505 High Acre Dr. T27 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status MYes 2 □ No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Trooper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis A. Kirkpatrick Blanche Columbus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Kirkpatrick-wife 505 High Acre Dr., T27, Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Variat 2 ☐ Cremation 3 ☐ Removal from State Pleasant Valley Cem 2-27-10 Westminster, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licensee Thomas 254 E. Main St. Westminster, MD 21157 V. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hapiration neumoni disease or condition resulting in death) Due to or as a consequence of): Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? fracture Spinal 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Coronary 24a. Was an autopsy perform Hernia 1 □ Yes 2 X No HIAtal 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Center Hospital: Other: 4 \sum Nursing Home 5 \sum Residence \textbf{X} \textbf{X} Other 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No Patient Fell, Hit Head 2 Accident 01/06/2010 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Nursing Home - Cherry wood 12020 Keiskrstown kd, Ma.

126 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Examiner The law requires that the death certificate be executed burial-tra physician the burial P.O. Box 68760. as Records. Division of Vital Hospital or Attending Physician: death. after death Director: filled in e Funeral C completely within 2

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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23a

Items

Director

Funeral

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Completed

injury or other traumatic event, the Medical Examinar hust be natified at

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Ite

permit. Pages 1 and Department of Healt Important: If item 2

Physician

/Medical

Examine

Be Completed by Physician/Medical

Certification: To

Medical

Doro

29b. Signature and title of certifier

Seay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Baltimore, Maryland 21215-0036

下十1

State Registrar

29c. License number

FEEESOOG

Smith Avenue Suite 203 Baltinune, Md 21209

29d. Date signed (Month, Day, Year)

21,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per dyr g900 2-23-10 vt/db State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Year Ronald J. Korecky 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** YARFORD BELAIRHEALTHAND 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🕅 M 2 🗆 F 79 Months Davs Hours Country) 0442429930 MD Director 213-28-1316 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Madical Examples. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD 1 Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5522 McCormick Ave 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?
1 □ Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give 1 Yes 2 No Specify: Specify: White 3 🕅 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Dept. Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Frank Korecky Stella Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph J. Korecky (Son) 749 Winterfield Ct Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Parkville, MD Signa re of Funeral Pervice Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir ail Rd Bel Air, MD 21014 1 610 W. MacPhail Rd Bel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on exhibine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 60 disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** 110012 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-trar Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial completed filled in by the funeral director, page 2 should be detached for use as the burial or page 2 should be detached for use as the burial or page 2 should be detached for use as the burial or page 2 should be detached for use as the burial or page 2 should be detached for use as the burial or page 2 should be detached for use as the burial page 2 should be detached for use as the burial page 3. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident М Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title offcertifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 30. Name applied described on the second sec

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 20, 2010 12:05 AM Jane Charlotte Krach /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1814 Wilson Point Road Middle River If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 02/23/1939 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2√2 F 70 Maryland Director 215-34-8537 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 28a-f show 1 ☐Yes 2 XNo Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 1814 Wilson Point Road 21220 U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ██No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas F.B. Miller Julia Weber ൧ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1814 Wilson Point Road, Baltimore, Maryland 21220 Kenneth Krach (Husband) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 02/24/2010 | Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 21. Signature of Funeral Sorvice Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immuniate Cause (Final divides as or condition ting in death) **Physician** / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of): Physician/Medical the attending IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav ρ in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. ed by the detached 9 Unknown 9 Unknown signed by t 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an selve performed? certificate ONIC Division of Vital the Hospital or Attending Physician: in 24 hours after death. the Funeral Director; After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 7

State

Registrar

29b. Signature and title o

31. Date filed (Month, Day,

HIN 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Amend #5, per Fh g900 2/23/10 TT amend item 20b per fh g901 3-2-10 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle | Last) 2. Date of Death 3. Time of Death **Physician** Month /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore (Margiand Baltimore
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.

 Min.
 3-24-1960
 last birthday, 2125-75 3798 9. Birthplace (State of Foreign Country)
Maryland 6. Sex **Funeral** 12 M 2□ F Director Usual Residence of Deceden 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show e notified at show MDN/A Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r Pages 1 and 2 should be filed within 72 hours after death with 1104 W. 21223 Lombard Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2KNo white Specify: à Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmotic. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/ADisabled 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Alfred Gottleib Karcher Deibert ဥ Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Karcher - Brother 56 Randall Ave, Lansdowne MD 21227 20b. Place of Disposition (Name of cametery, crematory or other place)
Glen Haven
Memorial Park 20a. Method of Disposition Date Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-5-2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road, Lansdowne MD 21227 el 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BMS /Medical Due to (or s a consequence of Examiner 13 Chemic unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or). requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as for use IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 9☐ Unknown ed by the a detached f 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Dirator 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy page Division or Vital 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 1 Inpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print) Sattzber 827 Linden Day, egistrar's Signatu State 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 18:24 2010 Medical 18 Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death TIMORE moma **Funeral** 1 M 2 KF Months Hours Director shov 10a. State ural", or items 23a or 28a-f sho Examiner must be notified at Town or Location 10d, Inside City Limits Director 1 XYes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral filed within 72 hours after death or all Hygiene. I hygiene. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Be Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working fe. DO NOT use retired) College (1-4 or 5+) ည should be Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Baltimore, thod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Metastatu Cancer disease or condition resulting in death) breast Medical Due to (or as a consequence of) **Examiner** Vena Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ansor 2438946 18/2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore 21218 Hospital MOZAYAN MANSOOR UNION Memorial 31. Date filed (Manth Day Year) 32. Registrar's Signature State Registrar

John Knott Oa/19/20c 2200 PM
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Jennifer Lee		State of Maryland / Depa	artment o rtificate o		Mental H	_	eg. No. 201	0 05053
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Tem; fer Lee	_			2. Date of Dea Month February	ith	3. Time of Death 0743 hrs
		4a. Facility Name (if not institution /give street and number) University Hospital		4b. City, Town, or L Baltimore	ocation of Death		4c. County of E	Death A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	→	F	9. Birthplace (State or oreign Country) Maryland
any		Usual Residence of Decedent	Town or Locat			Dec.	4137	10d. Inside City Limits
	ģ	Maryland N/A		Bath	more			1 Ves 2 No
ith the Maryland 23a or 28a-f sho notified at once	l Director	10e. Street and Number 8/2 Vine St.		10f. Zip Code	4201		Og. Citizen of What	A Country?
or items	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Widowed 4 Divorced of Dates.	1	es Decedent of Hispon es, specify Cuban, Yes 2 No	Mexican, Puerto specify:	Rican, etc.)	o- 14. Race - A White, e Specify: B	American Indian, Black, tc.
2 - 2	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during m	nt's Usual Occupation ost of working life. I	Provide	red)	16b. Kind of Busin	ess/Industry Te
MD 21215-0036 d.2 should be filed within 7 lith and Marlal Hygiene. n 27 is marked other than umatic event, the Medica	å	17. Father's Name (First, Middle, Last) Eugene Lee			LuEste	~ Juliu	-	
e, MD 21 Land 2 should Health and Me Titem 27 is ma		19a. Informator's Name/Relationship (Type, Print) Low Knath — daughter 20a. Method of Disposition 20b. F	19b. Mailing	Eleuthe	era Wai		nber, City or Town, Stabel Cr 20c. Location - Cit	ty N. Carolina
Baltimore, permit. Pages 1 a Department of He Important: If ite important: If ite njury or other to		1 Burial 2 Cremation 3 Removal from State	edar h		tery 2/	27/10 er Fun	Glen B	3
on ឱ្យ គួគ្គ Physician	4	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the	12-Fred	en'co uch as cardiac or	-	est, shock, or hear	Mayland Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Conveestive hour of the condition of the condition resulting in death)	eart fa	ilure cor ine) into	mplicate xication	ed by na	arcotic	Bétween Onset and Death
ed seight	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last underlying in death in the condition of the condition						
	edicai Ex	d.	20 - 6 -	E00	1 2/16/	10 mm		
6876 certificat inding physise as the	Σ!	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Vec 2 Ne 9 Vec Unicome 23c. If yes, outcome of pregrate 1 Live birth 4 Pregnant at time of december 25c.	nancy 2 Fe	ermE, g90 tal death 3 her (Specify)	Ectopic pregnar		23d. Date of del Month	ivery Day Year
	Dy Prny	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause giv	ren in Part I.			e to the cause of death? Probably 4 ✔ Unknown
	Completed			,		24a. Was autop	an 24b. Wersy prior	e autopsy findings available to completion of cause of h?
tal Recian: The		25. Was case referred to medical examiner?			f Death (Check o		2 No 1	Yes 2 No
on of Vit rding Physic th.: After this e funeral dire	2	1 ✓ Yes 2 No Tuspital 1 Inpatient 2 ✓ 7. Manner of Death 1 Natural 5 Panding 1 Natural 5 Panding	28b. Time of Ir	njury 28c. Injury	at Work?	28d. Describe I	Residence 6 0 now injury occurred mpound com	ntaining
Division o Sepital or Attending hours after death meral Director: After y filled in by the fune	eruncar	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) how		am	Iding, etc	or Town, S	Street and Number o	r Rural Route Number, City
To the Hosp within 24 ho To the Function completely formal		29a. Certifier 1 Certifying Physician: To the best of my knowledgenee) 2 Medical Examiner: On the basis of examination are			and place, and	due to the caus	e(s) and manner as	stated.
of Too of Too	- A	29b Signature and title of certifier		29c. License r			29d. Date signed	
OKOSUG		Name and address of person who completed cause of death (Item Ana Rubio MD. Assistant Medical Examiner		treet, Baltimore				
Stat	e ³	Date filed TEB 232010 22 Registrar's Signatur						

			Amend #11,	Please T	ype or Pri	nt in 3/10	Black Ir	ndeli	ole Ink	c. Ens	ure A	II Copi	es Ar	e Leg	ible.	
			For State Registrar		State of M	aryıar			nt of F te of D		and N	1ental H	ygiene Reg. N	00	IΠ	05054
П	Physicia	an/	1. Decedent's Name (First	t, Middle, Last)	in	?	1,	V.1.0	1/14			2. Date of E		ay	Year	3. Time of Death
-	Medi Examii		4a. Facility Name (if not in	stitution, give str	reet and number)) •	L	W C 4b. Cit	y, Town, or	Location of	of Death	d	40	. County	of Death	1 2 142 pm
1	F	Н	Joseph Rit 5. Social Security Number		17.40	o (In uro 1	ast birthday)		timo er 1 Year	ore If Under	21 Hrs	D Date of F	:41.		0. DI.:	
	Funeral Director		220-22-317	'8 ¹ ⅓	M 2 □ F 1. Ag	8		Months		Hours	Min.	8. Date of E (Month, I		29	9. Birth Coun MD	place (State or Foreign try)
	show dat	ē		dent County			y, Town or Loc							-	1	0d. Inside City Limits
	e Mary r 28a-f notifie	Direc	MD 10e. Street and Number			ва	ltimo		. 0- 1-							1 XYes 2 ☐ No
	s 23a o	eral	2923 W. La	nvale	Strett			101. 2	ip Code 2121	6			10g. C	itizen of W USA	/hat Cour	itry?
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 C	Married	2. Was Decedent I Armed Forces? 1X Yes 2 If Yes, Give Year or Dates.				edent of His ecify Cubar 2 🔀 No			cify Yes or No Rican, etc.))-		k, White,	
21215-0036	72 hou n "natu Aedical	nplet	(Specify or	Decedent's Educ nly highest grade	cation completed)		16a. Deced	kind of w	ork done di	ition uring most	t of worki	ng	16b. F	Kind of Bu	siness Inc	dustry
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Maryland	uld be filed I Mental Hy narked oth	To Be	17. Father's Name (First, M William S	. Lowe			T			Iona	a Ca	(First, Middle rroll	e, Maiden	Surname))	
Mai	d 2 shou alth and 27 is n		19a. Informant's Name/Re Lowina Low		, Print)							Route Numb				
		S) 3	20a. Method of Disposition	mation 3 🗆 Re	emoval from State	c	Place of Disposemetery, crem	sition (Na natory or	me of other place)	Г	ate	20c. L	ocation -	City or To	wn, State
Baltimore,	J # # -		4 Donation 5 21. Signature of Funeral S			Ga:	rrison				2/17 VWAS	/2010 ley C	Gai	rris	on,	MD
Ä	permit Depar Impor any in		Wesle	y Che	anstr		20	007	East	ern	Ave	. Bal	to.	, MD	2123	31
[Physician/ Medical		23a. Part 1. Enter the shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	eat, or complic e. It tonly one a.	cause on each line	Pro	state	r the mo	de of dying	, such as o	41	respiratory a	1	itai	IJ.	Approximate Interval Between Onset and Death
	Examiner	L	Saguaritally list condition	. [Due to (or as	a consequ	ience ot):									
٦,	ted nsit	Examiner	if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury	ite d	Due to (or as	a consequ	ience of):									
	e executed ian and irial-transit	al Exa	that initiated events resulting in death) Last	c.	Due to (or as	a consequ	ence of):								\top	
2092	icate be g physic is the bu	ledica		d.									_		\perp	
Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. The Puneral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medic	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ant	c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Feta	I death 3	Ectopic Other (s	pregnancy pecify)	,			*	23d. Date Mon		nry Day Year
Division of Vital Records, P.O.	law requires that the des has been signed by the a e 2 should be detached	क्र	Part II. Other significant o	conditions contr	ibuting to death b	ut not resi	ulting in the ur	nderlying	cause give	en in Part I.				/		e cause of death?
cord	law requ	Completed										24a. Was	psy	pr	ior to con	sy findings available npletion of cause of
al Re	an: The tificate tor, pag		25. Was case referred to m	nedical					26. Plac	ce of Deat	h (Check	1 🗌 Yes	ormed)		eath?	2 🗆 No
f Vita	Physici this cer al direc	욘	examiner? 1 Yes 2 No	Hos			ER/Outpatient		Other	: 4 □ Nui	rsing Hor	ne 5 Res				
o uc	nding Fath. r: After e funer	icate	27. Manner of Death 1 7 Natural 5 2 Accident	Pending Investigation	28a. Date of injui (Month, Day	y ; Year)	28b. Time of injury	М	28c. Injury work? 1 🔲 Y		- 1	8d. Describe	how injur	y occurred	i	
Division	To the Hospital or Attending Physician; The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate:	3 Suicide 6 🗆	Could not be determined	28e. Place of Inju building, etc			et, factor	y, office		2	8f. Location City or To			or Rural	Route Number,
	Hospi 24 hour Funer eted fills	Medical	(Check 2 □ Me	edical Examiner	an: To the best of On the basis of ex	camination	and/or investi-	gation, in	my opinion	. death occ	curred at t	he time, date	and place	and due t	to the cau	se(s) and manner stated
1	To the within To the compl	— r	only one) 3 L Ce	rtilying Nurse P	ractioner: To the	pest of my	knowledge, de	eath occi	c. License	time, date	and place	, and due to t	ne cause(s	s) and man te signed (ner as sta	ted.
	ر		20 Name to Late	ll	101300	alle /II	00-) 77 -		H			1		2	-10	7-10
	b		30. Name and address of p	On Kau	meteo cause of de	ath (Item	23a) (1ype, Pr BOW)	int)	82	72	inde	nAV	BO	elt 1	40	21201
	Stat Registra		31. Date filed (Month, Day,	Year) B 2 3 20	32. Registra	r's Signati		bar	1							

DHMH 17 Rev 7/2009

WILLAM LOWERY

			_ State	tate of Marylan		artment of F			0010	05055
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate or i	Dealli —————	2. Date of Dea	Reg. No.	3. Time of Death
	Physici /Medio		Louise W	. Lev	ine			Month Februar	Day Yea	r
	Examin		4a. Facility Name (If not institution, give stree	,		4b. City, Town, or	r Location of Death		4c. County of De	
-			Renaissance Garden			Silver	1		Montgome	ery
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	v, Year)	Sirthplace (State or Foreign Country)
			Usual Residence of Decedent	92				May 26,	1917 Mas	ssachusetts
	arylan show	ř	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	the Ma	Director	MD Montgomery 10e. Street and Number	Sil	lver Sp					1 □Yes 2XQANo
	3a or	Ö	3110 Gracefield Rd			10f. Zip Code 20904			10g. Citizen of What C United St	•
	death	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S	S. 13. V	Vas Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - An	nerican Indian,
36	or ite		1 Never Married 2 Married 1	Armed Forces? I∐Yes 23⊠No fYes, Give		r Yes, specity Cuba I∐Yes 2XTXNo	an, Mexican, Puerti Specify:	o Rican, etc.)	Black, Wh	
Ö	hours tural"	ed by	3€XWidowed 4 LI Divorced Y	ear or Dates:						
7	iin 72 in "na Nedic	Completed	15. Decedent's Educatio (Specify only highest grade cor	npleted)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of wor	king	16b. Kind of Busines	s/Industry
212	d with	Som	Elementary/Secondary (0-12) C	College (1-4or 5+)	Artis	st			Commercial	Art
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland than Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, it as fredient Examination, ust Dominital at	Be	17. Father's Name (First, Middle, Last) Herbert H. Walls				_		Maiden Surname)	
<u>₹</u>	d Men narke natic	2						. Nichol		
<u>a</u>	id 2 sh Ith an 27 is r traur		19a. Informant's Name/Relationship (Type. F Frederick S. Koontz	r _{int)} (attorney)					r, City or Town, State	
ā,	s 1 an f Hea item 2		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of			Baltimore,	
altımore,	Page: nent o int: If		1 ☐ Burial 2 【XCremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	vai from State		natory`or other plac e Cremato		510^{23} ,	Beltsville	, MD
alt	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of F neval S rvice Licensee		22	. Name and Addres	ss of Facility Raj	op Funer	al & Crema	tion Service
מ	80 E 8 9		Drieding	M0098	32 9	33 Gist	Ave. Silv	ver Spri	ng, Maryla	nd 20910
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death use on each line.	. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
٠., F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Dementia						years
and a	Examiner			Coronary Ar	,)i casea				woons
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		136436				years
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Hypertensio						years
٦ و	cate be executed physician and the burial-transit	al Ey	resulting in death) Last	Due to (or as a consequ	ence of):					
08/PU	p phys	edical	d			·				
POX	n cerri endinç use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If	yes, outcome of pregnar					23d. Date of d	elivery
ים ה	e dear	sicia	1 □Yes ŽŽXNo	Live birth 2 Fetal Pregnant at time of de		Ectopic pregnancy Other (specify)	y 		Month	Day Year
Ϋ́ :	d by t	Phy	9 ☐ Unknown Part II. Other significant conditions contribu		No a in the case		- i- D	OG Did to	h	A- #
່າວ	signe d be c	d by	Tartin. Other significant conditions continue	ling to death but not resul	iling in the un	deriying cause give	en in Part I.			to the cause of death? Probably 4 🔀 Unknown
ecords	w requ	lete						24a. Was a		
ب ت	feath. for: After this certificate has been signed by the ithe funeral director, page 2 should be detached	Completed						autops perforr	sy prior to med? death?	
VICAL	rtifica stor, p	0	25. Was case referred to medical				26. Place of Deal	1 □Yes : th (Check only on	2 ⊠No 1 ⊡ Ye ne)	es 2 □No
5	this ce	To B	examiner? 1 ☐ Yes 2 🖾 No	1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3 □ DOA Othe			ence 6 ☐ Other (Sp	ecify)
	After I	ion	1 XNatural 5 ☐ Pending	Ba. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	y at	28d. Describe ho	ow injury occurred	
SIOIL	death ctor: y the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Be. Place of Injury - At hor	me farm stre		Yes 2 □ No	28f Location (Ct	troot and Number or I	Queel Pouto Number
2	d in b	ertii	4 ☐ Homicide determined 28	building, etc. (Specify,)	et, ractory, office		City or Town	treet and Number or F n, State)	surai Houte Number,
1			29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	1: To the best of my know	vledge, death	occurred at the tin	ne, date and place	, and due to the d	cause(s) and manner	as stated.
4	the F	Medical	5/16 <i>)</i> 8	and manner stated.	- Ion and/or inv					
, i	S 5 € 8	-	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mor	IIII, Day, Year)
1	X,/	-	30. Name and address of person who comple	ted cause of death (Item	23a) (Type P	Print) -	1000)	2/22	110 Her Spring MD
	0 V		Katherine Ja	intac C	RNP	316	O Grai	efield	Rd. Sili	ler spring MID
	Stat		31. Date filed (Month, Day, Year) FFR 2.3 2010	32. Registrar's Signatu	ure					2092
	Registra	II .	FE GO ZUIU	Charge B	MAR	Mad				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day D. Year Warren Lewis Month 4:02A M FEB 20 /Medical 2010 4a. Facility Name (If not institution, give street and number)
Good Samaritan Hospital Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 227-08-6582 1 X M 2 F **Director** 8/8/1971 Virginia Usual Residence of Decedent 10a. State show 10c. City, Town or Location Baltimore 10d. Inside City Limits r than "natural", or items 23a or 28a-f should be rectified at MD Baltimore Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2717 Inglewood Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married P Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 → No Specify: Specify: Black ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Computer Testipg Elementary/Secondary (0-12) College (1/4or 5+) Client Service Mgr. 127 is marked other er traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Not Avail ဂ္ Mary E 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2717 Inglewood Ave Baltimore, MD 21234 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troonce. Maureen Lewis / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Serv. Corp. 2/24/2010 Towson, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only line cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician pancreatitis necrotusing disease or condition resulting in death) a. Acute /Medical Due to (or as a consequence of): Examiner b. Acute renal Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tension, meniscal 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed? 2 No 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 MD 2010 FEB 20

State Registrar LOCHRAVEN BLUD BALTIMORE

MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

82. Registrar's Signature

NAMDINI YADAV

31. Date filed (Month, Day, Year) FEB 2 3 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, August 21 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 219-30-4741 Country) Mary Land Director 77 Lisual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🗖 No Maryland Anne Arundel Pasadena 10e. Street and Number 23a or 3 10f. Zip Code 10g. Citizen of What Country? Funeral 363 North Ferry Point Road 21122 U.S.A. or items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvin Zachary Guerydan 19a. Informant's Name/Relationship (Type, Print) of Health and item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Stephanie Lane Weber (Daughter) 13105 Manor Road, Glen Arm Maryland 21057 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State ö Crownsville VA Cemetery injury o 4 ☐ Donation 5 ☐ Other (Specify) Feb.25, 2010 Crownsville, Marylan d 21. Signature of Functal Service License 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweel Immediate Cause (Final Onset and Death Physician/ Isease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated exercises) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and that initiated events resulting in death) Last use as the burial-trar signed by the attending physician I be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy 1 Yes 2 No 2 No ☐ Yes sompleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🕍 No Other: ပ 1 DOA | 1 DOA | 1 DOA | 1 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred $5 \square$ Pending 1 🗌 Yes Accident Investigation 2 🗆 No Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 2 Day Physician/ 0945 PN 2010 ChAEL EdWARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1√2 M 2 □ F Months Days Hours Min. 578-74-<u>5718</u> Director Ashington, DC Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location Director ty Yes 2 No MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 109 E. Hillcrest Road, Apt. 21740 USA items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married Examir Yes 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced "natural" Completed White Year or Dates Health and Mental Hygiene.

em 27 is marked other than "natur.

ther traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Yvonne Arnold Cecil W. Minard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Gardens, #204, Hagerstown, MD 21742 <u>Mary F. Minard/Ex Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of I-Important; If ite any injury or oth 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services 02/22/2010 Hanover, MD 21. Signature of Juneral S ice licensee 22. Name and Address of Facility ARDEST CREMATION SYTUICS 31076 HANOUIR 7532 CONVELLEY DE STE.N. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ENCEPHAZO PATITY Physician/ HEPATTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MITROMBO CT POPENIA Sequentially list conditions Examiner Due to for as a consequence of If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury RHABOOMTOLTSIS the burial-transi that initiated events Due to (or as a consequence of): attending physician Physician/Medical DISGASG CHRONIC LIVER Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant g Unknown Pregnant at time of death is certificate has been signed by the a director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of ALCO HOL 24a. Was an autopsy performed death? I or Attending Physician; The Is after death.
Director; After this certificate h 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funeral C Hospital completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0006200 G 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID AUTAGO-WIRTON ANTI STAM 57-HITHERESTOWN 251 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a,25 per me,g900,02/23/2010dhb Mental Hygiene For State **Physician** /Medical Examiner **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylant Department of Health and Mental Hygiene.
Important. If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Wedical Evarrine must be notified at once. JAMES Baltimore, Maryland 21215-0036 ACNEAL

> **Physician** /Medical Examiner

I

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

		em 24a,25	per me,	5 90 0 Cer	1,02/23/2 tificate of l	Olodhb Death	, wertar ri	Reg. N	20	0	0505
n	1. Decedent's Name (First, Middle, La James William Ma	,					Date of D Month		Day ^	Year	3. Time of Death
ıl	4a. Facility Name (If not institution, give				4b. City, Town, or	Location of De	021	0	lc. County of	O Dooth	10:05P
r	Good Samaritan H				Baltimor		411		Baltin		
	,	Sex 7. Ag	e (In yrs. last birt	thday)	If Under 1 Year Months Days	If Under 24 H		irth			lace (State or Fore
	212-01-6560 Usual Residence of Decedent	ILEM ZLIF	90	Yrs.	Wionins Days	1 louis	June 2	4,]		Mary	
	10a. State 10b. County		10c. City, Town	or Loc	cation					10	Od. Inside City Limi
5	MD Balti	more	Balt	imo	re						1XYes 2□N
ם הובי	10e. Street and Number 5404 Ready Ave.				10f. Zip Code 21212				Citizen of W	hat Count	try?
be completed by runeral Director	11. Marital Status unk 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 I If Yes, Give Year or Dates:		l .	Vas Decedent of Hi Yes, specify Cuba □Yes 2X No	ispanic Origin? n, Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)	0-		- America , White, e whi	tc.
חוואופובי	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) unk	ducation ade completed) College (1-4or 5 unk		Deced (Give I life. D	ent's Usual Occup kind of work done o OO NOT use retired	ation unk furing most of w)	orking	16b.	Kind of Bus	iness/Ind	ustry unk
2000	17. Father's Name (First, Middle, Last James Walter MacN)					ame (First, Middle Mae Trac		en Surname)	
	19a. Informant's Name/Relationship (Good Samaritan Ho	Type Print) Ospital	19b. 56	Mailing 01	g Address <i>(Street &</i> Loch Rave	and Number or I en Blvd;	Rural Route Numb Baltimo	ber, City	or Town, S Mary	State, Zip 1and	^{Code)} 21239
i	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of cemeter	Dispos y, crem	sition (Name of atory or other place	9)	Date	20c.	Location - C	City or Tov	wn, State
	21. Signature Funera S lice Lice	Vade bive			Name and Address ate Anato 1timore,			V. B	Baltim	ore	Street
	23a. Part 1. Enter the disease for com- shock, of heart failure. List only Immediate Catse (Final disease or condition resulting in death)	a. My O	the death. Do note.	al	the mode of dying	g, such as cardi	ac or respiratory a	arrest,			Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence o								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🔲 Fetal death		Ectopic pregnancy Other (specify)				23d. Date Mont		ry Day Year
	Part II. Other significant conditions o	ontributing to death bu	it not resulting in	the und	derlying cause give	n in Part I.					e cause of death?
							24a. Was auto perfo 1 □Yes		24b. We pri de	ath?	sy findings availab pletion of cause of
	25. Was case referred to medical examiner?	Hospital:			Othe	r·	eath (Check only				
-	1 ☐ Yes 2 💹 No 27. Manner of Death	28a. Date of Injur	y 28b. Ti		3 LI DUA	4 LI Nursing	Home 5 ☐ Res)
	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year) In	jury	28c. Injury Work' M 1 🗆 Y	່ ′es 2∐No	250. Describe	NOW IIIJI	ary occurred		
	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farr . <i>(Specify)</i>	n, stree			28f. Location (City or To	Street a	and Number te)	or Rural	Route Number,
	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	yslcian: To the best on niner: On the basis of and manner sta	examination and	death l/or inve	occurred at the timestigation, in my op	e, date and plac pinion, death occ	ce, and due to the curred at the time,	cause((s) and man nd place, ar	ner as stand due to	ated. the cause(s)
	29b. Signature and title of certifier				29c. License	number		29d. D	ate signed	(Month, D	Pay, Year)
	CAS_	MD			RES	000		0	2/0	9/1	D
	30. Name and address of person who						20	0.6		1	1, 2, 3, 2

State

Registrar

31. Date filed (Month, Day, Year)

FEB 23 2010

park

32 Registrar's Signature

		•	For State Registrar	State o	f Marylan	•	artmen <i>tificate</i>			Mental Hyg	jiene og. No:	10	05060
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	/Medic Examin		4a. Facility Name (If not institution, gire		mber)		4b. City,	Town, or	Location of Deat	h	4c. Cour	ity of Death	
	Exami		2 Alloy Cir	cle					lle Riv			altir	
	Funeral Director			Sex 1.□XM 2.□F	7. Age (In yrs.		If Under Months	1 Year Days	If Under 24 Hrs Hours Min.		1943	9. Birthp Cour	lace (State or Foreign htry) MD
_	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
A	ith the Marylan or 28a-f ehow	or	MD Balti	more			dle	Rive	er				1 ☐ Yes 2X No
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0850AM	death with the Maryland ms 23e or 28a-f ehow	aiD	2 Alloy Circ	le				2122	20		USA		
	s 1 and 2 should be filed within 72 hours after death with the Maryla Heelth and Mental Hygiene. Item 27 is marked other then "nature!" or items 23e or 28e-f eho other traumatic event, the McCical Examiner must be notified at	by Funerai	11. Marital Status	Armed Fo		J.S. 13. \	Was Deced f Yes, spec	dent of Hi city Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. R	ace - Americ lack, White,	
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5	/sicie s certi	To Be	examiner?	Hospital:	Inpatient 2] ER/Outpatier	nt 3 D	Oth Oth		v.	lence 6 🗆 (Other (Speci	fy)
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DHMH 17 Rev 1/2001

ORIGINAL

hours after death Funeral within 24 To the

Medical

State Registrar one)

29b, Signature and title of certifie

Laron Locke MD

FEB 23 2010 32. Registrar Signatu

30. Name and address of person who completed cause of death (Item 23a)

00ME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 12, 2010

Assistant Medical Examiner

and manner stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 7, 2010 **Physician** 2345 P Minor Marrie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Cheverly Prince Georges Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. (Month, Day, Year) 03/12/1939 1 M 2 J 70 Washington, DC 578-54-9435 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 □ No Capitol Heights ral", or items 23a or 28a-f sh Examiner must be notified MD Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 USA 1207 Addison Road #126 by Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
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MD 20748

Freeman Funeral Services 4594 Beech Road; Temple Hills, 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Ceuse (Final Chronic obstructive pulmonary disease Approximate Interval Between Onset and Death **Physician** Chronic obstructive pulmonary disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed after death. physician and s the burlal-trans resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 ☐ Other (specify) signed by the a t be detached f 1 □Yes 2 □Xo Division of Vital Records, P.O. 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ha 1 ☐Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in To the Hospital within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0068294 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theophilus Botwe 3001 Hospital Drive; Cheverly, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park Registrar

DHMH 17 Rev 1/2001

			Pleas	e Type or Prir					-	`	gible.	
			For State	State of Ma	aryland	•	artment of F tificate of		,	0/	210	00000
	_	-	Registrar 1. Decedent's Name (First, Middle,	(201)		Cei	lilicate of	Dealli	2. Date of De	Reg. No.		3. Time of Death
	ysicia		Aubra Natha		ffati	t Sr.			Month FEBruar	Day	2010	2.51 AM
	Medic camin		4a. Facility Name (If not institution,		TTEC	L DI.	4b. City, Town, o	or Location of Deat			nty of Death	
	. Carrini	C1	Smal Hospita	4 4 0	more	0	Bultome	ose Oh	1	N/	A	
Fun	neral		5. Social Security Number 6	. Sex 7. Ag	e (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	y, Year)	Cou	place (State or Foreign intry)
Dire	ctor		220-40-9574	HASINI ZUF	66	Yrs.			11/16	1943	Mary	yland
land	_		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation			-		10d. Inside City Limits
Mary	fied a	ţ	MD N/A				Balti	imore				1 XYes 2 No
h the	noti	irec	10e. Street and Number		1		10f. Zip Code			10g. Citizen	of What Cou	intry?
Ith wil	ust be	Funeral Director	2708 Oakley A	venue			2121	15			.S.A.	
er des	ler m	nue	11. Marital Status	12. Was Decedent I Armed Forces?		. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. F	Race - Ameri Black, White,	
rs afte	camir	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 1 1 If Yes, Give Year or Dates:	No		1 □ Yes 2 ½ No	Specify:		Spe	cify: Bla	ack
G KIKID-UUDO filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show	cal E	ed	15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation		16b. Kind of	f Business/Ir	
	Medi	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	5+)	(Give life. l	kind of work done DO NOT use retire	during most of wo	rking			
A wit diene	t, the	Completed	10th Grade		.,	Do	g Trair	1				oloyed
be fig tal Hy doth	eveni	Be	17. Father's Name (First, Middle, La	·				18. Mother's Na	me (First, Middle	, Maiden Surr	name)	
2 should be filed within and Mental Hygiene. Is marked other than	natic	ပ္	Nathaniel	Moff	<u>ett</u>	401 14 11			Mae	Barbe		
d2st d2st than 7 Is n	other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship					t and Number or R		-		
Heal	other		Joyce Moffett 20a. Method of Disposition	(wire)	20b. Pla		sition (Name of natory or other pla	Ave.,I	Date	20c. Locatio		
Daltillore, ING permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is	y or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				natory or other pia 1 Forest	1	03/10	Balti	more	MD
mit. F	声		21. Signature of Funeral Service Lie		Gari			ass of Facility Brown				
Ded E	any lr		pequeline	6. Koa	ac	ر 2 س	2140 N.	Fulton	Ave.,E	altim	ore,	MD 21217
			23 / Prt1. Frier the disease, or co	omplications that caused ily one cause on each lir	the death.	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
Physic	cian		Immediate Cause (Final disease or condition	· Acute	MU	ocar	dial)	afarct	ron			Onset and Death
/Med Exam			resulting in death)	Due to (or as	a consuque	ence of):	0	nfanct				1 0000
LAdili	231	-	Çequentiany nat conditions,	Due to (or as	M	arh	eny di	sease	_			mknown
ted	nsit	Examiner	rif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as	a conseque	ince oi).	J					
be executed	burial-transit	Exar	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						
te be ey	pnr	<u>e</u>		d								
rtifica ng ph	as th	Physician/Medic	IE EEMAL E.									
ath ce tendii	or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	:y			Date of delive	/ery Day Year
the all	hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of dea	ath 5□	Other (specify) _				WOITH	Day Teal
that the	detac		Part II. Other significant condition	s contributing to death b	ut not result	ina in the u	iderlying cause giv	ven in Part I.	23e. Did 1	obacco use c	ontribute to	the cause of death?
uires uires	d be	d by	hugertension	Ů			, , ,		1 🗆	Yes 2 No	3 - ro	obably 4 ∐Unknown
w req	nous	Completed	icalianala cadi	Iomyopathi	1				24a. Was	an 24	lb Were aut	opsy findings available
The la	age 2	dwo	15cravnic Cora	ongopuni) 				auto perfo	psy ormed?	prior to co death?	ompletion of cause of
lan: lan: rtifica	tor, p	Be	25. Was case referred to medical					26. Place of De	1 Yes ath (Check only o	2 No	1 ☐ Yes	2 □ No
ysic nis ce	direc	To B	examiper? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 E	R/Outpatier	t 3 DOA Oth	ner: 4 🗌 Nursing I	Home 5 ☐ Resi	dence 6 □	Other (Spec	ify)
ng Pl	ınera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe	how injury occ	curred	
tendi leath. tor: A	the fu	catio	2 Accident investigat 3 Suicide 6 Could not					Yes 2 □ No				
or All	in by	Certification:	4 Homicide determine	building, etc	ury - At hom c. <i>(Specify)</i>	ie, farm, str	eet, factory, office		28f. Location (City or To	Street and Nu wn, State)	mber or Rui	ral Route Number,
spital	filled		29a. Certifier 1 Certifying	Physician: To the best of	of my know	ledge, deat	occurred at the t	ime, date and place	e, and due to the	cause(s) and	manner as	stated.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys	letely	Medical	(Check only 2 Medical Ex	caminer: On the basis of and manner sta	f examination	on and/or in	vestigation, in my	opinion, death occ	urred at the time	date and place	ce, and due	to the cause(s)
To th Withir To th	сош	Me	29b. Signature and title of certifier	111 :			29c. Licens	se number		29d. Date sig	ned (Month	, Day, Year)
1			ain MI	Golgin M	0		RE	5-00	00	FEB.	Nan	116,2010
+1			30. Name and address of person wh	C 1 A	^	23a) (Type,	Print)	: 0 = 1	2 // /		J	, , , , ,
1			31. Date filed (Month, Day, Year)	OQM M 32 Registra	ar's Signatu	Me	1 Hospi	ial of l	Salm	exce		
Re	Stat gistra		FEB 23 2		4	Lo	arel	,				

DHMH 17 Rev 1/2001

		L	1 - For State Registrar	State of Marylar		artment of He rtificate of E			gierre 0 1 0	05054
	Dhorisi		1. Decedent's Name (First, Middle, La	ist)				2. Date of De Month	ath Day Year	3. Time of Death
	Physici /Medio		Betty Fa	irbanks M	lanning			Februa		
н	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Dea	th	4c. County of De	ath
			ManorCare of Du	laney		Towson			Baltime	ore
I	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)		If Under 24 Hrs Hours Min		th 9. Bi	irthplace (State or Foreign Country)
	Director		218-14-3974	^{1□M 2} XF 86	Yrs.	Months Days	110013	July 2		aryland
	pu 🖈		Usual Residence of Decedent 10a. State 10b, County	10. 0	· · ·					T
	aryia shov	-	Too. State Too. County	100, C	ty, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	Ba-f	Sct	Maryland Baltim	ore	Timon					
	vith ti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	ath v		508 Limerick Ci			2109			USA	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of His f Yes, specify Cuban	spanic Origin? (: n, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - Am Black, Wh	
3	be filed within 72 hours after death with the Maryland that Hygiene. od other then "natural", or flems 23a or 28a-f show event, I're Medical Eracin writinal be invitiled at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give		1□Yes 2፟X No	Specify:		Specify:	
215-0036	hour	D		Year or Dates:	10- D	4				hite
ည်	n 72	Completed	15. Decedent's E (Specify only highest gra		(Give	tent's Usual Occupat kind of work done du DO NOT use retired)	uring most of wo	orking	16b. Kind of Busines:	s/industry
7 7	withi ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		· ·			Education	
	filed Hygi ther	ပိ	17. Father's Name (First, Middle, Last		1	eacher	18. Mother's Na	me (First, Middle.	Education Maiden Surmame)	011
yland		Be c								a == 1 = =
<u></u>	2 should be and Mental 1s marked (raumatic ev	၉	John Lawre 19a. Informant's Name/Relationship (ington	n Address (Street at	Ethel		Fairba er, City or Town, State,	
Ma	d 2 s th ar 17 is trau									
a)	1 an Heal em 2		Michael A. Manni 20a. Method of Disposition					Date	20c. Location - City o	m, MD 21093
ğ	ages of of		1 X Burial 2 ☐ Cremation 3 ☐	Judinoval nom State		sition (Name of natory or other place			0 2 7 7 7 7	
Saitimo	rtme rtant riant		4 □ Donation 5 □ Other (Special	7 1 110		Cemetery		d 1-10	Baltimore,	Maryland
a D	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury or other traumatic a <u>pnce</u> .		Bryan W. Clar	aser	22	Name and Address Lemmon Fur 10 W Padd	neral H	ome of D	ulaney Vali	ley Inc.
			23a. Part1 nter the disease, or com shoot, or heart ailure. List only	plications that cause the deat	h. Do not ent	er the mode of dying	, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (inal disease or common	VEME A	MIA	08 4	4124	EIME	- 102	Onset and Death
	/Medical		resulting in death)	a. Due to (or as a conseq	mence of):	1 11	1-6-11	C11/E	トバン	V200-0
	Examiner	H		TYPE	30,100 0.7.					years.
		-er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of):					1
	uted d ansit	Ē	that initiated events							
2	exec in an ial-tr	Examiner	resulting in death) Last	Due to (or as a conseq	uence of):		*			
0/0	icate be executed physician and the burial-transit	dical		d						
^				70.						
Š	andin use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		L			23d. Date of de	elivery
٥	death a atte d for	lcia	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
,	the oy the acher	hys	9 Unknown	9□ Unknown						
ŗ	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	by P	Part II. Other significant conditions of	contributing to death but not res	ulting in the ur	ndertying cause giver	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?
cords,	aufre n sign ald be							1 🗆 1	res 2 □No 3 □ F	robably 4 Unknown
5	w rec	Completed						24a. Was	an 24h Were a	autopsy findings available
ב ב	he la s has ge 2	E D						autop	osy prior to rmed? death?	completion of cause of
<u> </u>	n: Tl ficate or, pa	_	OF 1W 4					1 ☐ Yes	2 No 1 □ Ye	s 2□No
N I I	siclar certi recto	Be	25. Was case referred to medical examiner?	Hospital:		Other		ath (Check only o		
5	Phys ral di	٠ <u>.</u>	1 ☐ Yes 2 🔼 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of	28c. Injury	4 Nursing		dence 6 Other (Spenow injury occurred	ecify)
200	Jing After fune	<u>6</u>	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work?	es 2 No	280. Describe i	low injury occurred	
2	tten deatl stor: r the	ical	2 Accident investigation 3 Suicide 6 Could not b	O Diago of Injury At he	ama farm atu		92 5 140	206 Location /6	Street and Number or F	Rumi Pouto Alumbar
<u> </u>	or A after Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	et, ractory, onice		City or Tox	vn, State)	rurar noute reumber,
	pital ours a eral filled		29a. Certifier 1 X Certifying Ph	ysician: To the best of my kno	wledge death	onnurred at the time	date and -le-	a and due to the	cauco(c) and many	as stated
	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death, To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2 s.	edical	(Check only 2 Medical Exer	niner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my opin	nion, death occ	urred at the time,	date and place, and du	e to the cause(s)
	o the	Me	29b. Signature and title of certifier	21		29c. License	number		29d. Date signed (Mon	nth, Day, Year)
	⊢≯⊢ŏ		· ATTI	lad in		2)-1	2849	?	2-17-11	0
			20 Name and a discourse	w v Cev "	- 02-\ T	2-1-1)	011			
	5 V		30. Name and a dress of person who	completed cause of death (Item	n 23a) (Type, I	FINT)	Dr. This	NSON	2-17-16 MD 3	21204
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture .	1	- 101	0011		
	Sta Registr		FFR 23	2010	A	ha Kal				

MAMA 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

SIBAL



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

29d. Date signed (Month, Day, Year)

AVE - BALTIMORE

athleen Moore	1- For S	State of Maryland / Department of Health and Mental Certificate of Death		2010 05066
Physician	Registra		Reg. 2. Date of Death	3. Time of Death
adical Examine		athleen Moore	February 16,	
		lity Name (if not institution, give street and number) 4b. City, Town, or Location of De Catonsville	eath	4c. County of Death Baltimore County
Funeral		al Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	271	f-32-3149 1□M 21/2F 82 Yrs. Months Days Hours	Min. 08/25/	1927 Country) NC
		tesidence of Decedent		10d. Inside City Limits
ow any	10a. St	10b. County 10b. County 10c. City, Jown or Location Windsor Mill		1 Yes 2 No
Maryland 28a-f show	10e. St	reet and Number 10f. Zip Code	10g.	Citizen of What Country?
th the Maryland 23s or 28s-f sho notified at once	10e. St 108	Village of Pine Ct. Apt. 20 21244		USA
		ital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
er deal		Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1 Yes 2 No No specify:		Specify: Black
ours aft		lor Dates: accedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		6b. Kind of Business/Industry
136 hin 72 hours a lie. than "natural edical Examin	Elen	Nentary/Secondary (0-12) College (1-4 or 5+)	ock (ChildCare
5-0036 led within 72 hours after death w Hygiene other than "natural", or items the Medical Examiner must be	17. Fat	her's Name (First, Middle, Las)) 18.Mqther's N	Name (First, Middle, Mai	iden Surname)
21215-0036 Auld be filed within 7 Mental Hygiene. The warked other than c event, the Medica		urvin Crawford duc		urphy
ore, MD 21215-00: es 1 and 2 should be filed with of Health and Menual Hygiene If item 27 is marked other t ither traummatic event, the Mes	0 19a Jn	formant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number) 108 Village of Fine (or, City or Town, State, Zip Code 21244
imore, MD 2 Pages 1 and 2 shoul ment of Health and In tant: If item 27 is it or other traumatic	20a. M	ethod of Disposition 20b. Place of Disposition (Name of cemetery,	Date 2	20c. Location - City or Town, State
		Burial 2 Cremation 3 Removal non state Mt. 720 Come terry 3	2-27-10	Baltimore, MD
Baltimo permit. Pag Department Important: injury or of	21. 96	nature of Funeral Service Lice Lee 22. a and a tress of cilly	reene Fun	eral Services
	1232 P	art I. Egite the disease, or complications that caused the death. Do not enter the mode of dying, such as card	ti Pile	t, shock, or heart Approximate Interval
Physician /Medical	fa	ilure. Nist/ nly one cause on each line.		Detiredit dilate and
Examiner		iate Cause (Final disease a. FULTIMORARY CHROINDOCHIDOLLISM COMPLICA dition resulting in death) Due to (or as a consequence of):		
	Seque	ntially list conditions, leading to immediate b. Due to (or as a consequence of):		
	⊆ cause	Enter Underlying Cause se or injury that initiated Due to (or as a consequence of):		
cuted and transit	events	resulting in death) Last Due to (or as a consequence or).		
be executed sician and nurial - trans	agica X	UNPENDED $23a,PII,27,28a-f$, per ME g904, 6/8	/10 TT	
760, icate by physic the bur		MALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery Month Day Year
ox 6876(eath certificate attending phy.	pa gi	st 12 months? 4 Pregnant at time of death 5 Other (Specify)	, og	
က ုံ နိုင္ငံု	≥ '=	Yes 2 V No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did toba	acco use contribute to the cause of death?
P.O. es that the iigned by be detach	ক্র	Status post fall-2005		2 No 3 Probably 4 V Unknown
ords, F w requires s been sig	eted -	scacao post rarr 2005	24a. Was an	
COF e law r te has b ge 2 sh	Completed		perform	ed? death?
ital Rec ician: The l s certificate h	a 25. W	as case referred to medical 26 Place of Death (Cl		
Vita	<u>0</u> 1	Yes 2 No		esidence 6 V Other: Scene
n of ding Ph		anner of Death 28a Date of Injury (Month, Day, Year) Natural 5 Pending 28a Date of Injury (Month, Day, Year) 1 Yes 2 X N	associat reposition	w mjury occurred in jury ed with probable patien ing in her nursing home
Sion Atten	2 X	Accident Investigation unk lunk Land Lan	28f. Location (St	reet and Number or Rural Route Number, City_
Divis	Certification:	Homicide determined (Specify) Nursing Home	Randall	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a. C (Check		e, and due to the cause irred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To the Ha within 24 To the Fu completed	29a. (Check one) 29b S	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated 29c License number		29d Date signed (Month, Day, Year)
		O.C.M.E.	OCME	February 20, 2010
6	3 No	ame and address of person who complete city e of death (Item 23a)		
\mathcal{X}	ĮΤ	heodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Balti	imore, MD 21201	
Sta Regist	ate ^{31. Da}	ate filed (Month, Day, Year) FEB 2 3 2010 32. Registral—Signature		
DHMH 17 Rev 1/20		ORIGINAL		

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 20 Month OZ MILLER 19:01 SHIELE ZO LO Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner CMALKSAM MODICAL GENTER UNIVERBITY OF BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) lay 21,1934 Country) Maryland 213-32-5818 75 Director May Lisual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 7489 A Furnace Branch Road 21060 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: If Yes, Give white "natural", Completed 3 Divorced 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) should be made hygiene.
h and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William J. Mahle Marie unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 7489 A Furance Branch Rd. Edward Miller spouse other Glen Burnie MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ō 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. injury 2/22/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland 21. Signature of Ineral Service Lices 22. Name and Address of Facility Stallings Funeral Home P.A. <u>3111 Mountain Road Pasadena MD 21122</u> 23a. Part 1 Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final MOCARDIAL Physician/ PERL OPERATIVE INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ANGINA NOTABLE NOTEM Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying -transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) -burialattending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Vear 4 ☐ Pregnant a 9 ☐ Unknown ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be (DM, CHF, HTN, HLD, HIT, Records, 1 Yes 2 No 3 Probably 4 Unknown RADIATION CHANGES 27 40 24b. Were autopsy findings available prior to completion of cause of death? LYMPHOMA 24a Was an Hospital or Attending Physician: The law has page 2 performed? this certificate 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural injurv 5 Pending Accident work?
1 Yes 2 No after death Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Direct

completed filled in by Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

To the I within 2

(Check

only one 29b. Signature and titl

3 🗆

30. Name and address of person

MD

who completed cause of death (Item 23a) (Type, Print)

32. Registra

22 5, GREENE ST.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

20

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BALTIMORE, MD.

2010

29c, License number

	•	For State Registrar		State of	Marylar		artment of F rtificate of I		•	giene Reg. No.	010	05068
Physicia	ın		e (First, Middle, Las						2. Date of De Month	Day	Year	3. Time of Death
/Medic	al .		R. McMast		nher)		4b City Town or	Location of Deat	Feb.		2010 County of Death	2:30 A. M
Examine	er	206 Warre		or cor and man				ckeysvil			ltimore	
Funeral Director		5. Social Security N 222–12–09		ex □ M 2 Ă F	7. Age <i>(In yrs.</i> 82		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April (7, 19	9. Birth Cou D	place (State or Foreign ntry) elaware
and w		Usual Residence of 10a. State	f Decedent 10b. County		10c. Ci	ty, Town or Lo	cation				1	10d. Inside City Limits
Maryl	to	Maryland	Baltimor	e Count	у Со	ckeysv	ille					1 ☐ Yes 2 No
ith the	Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
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urs a	by Funeral	 Marital Status Never Marr Widowed 	ried 2 ☐ Married 4 ☒ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	rces? 2 _kt No ∕e		Was Decedent of H fYes, specify Cuba I □Yes 2 XNo	Specify:	o Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh	etc.
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led wil lygien her th		12		02	·]	Legal Sec		- (First Adiabatio	Maidan 6	Law	
d be fill be fill be ded out	Be C	Hervey Re	(First, Middle, Last)					18. Mother's Nar Pearl Ha		, maiden s	Surname)	
should and Me s mark umati	2		ame/Relationship (7)	ype. Print)		19b. Mailir	ng Address (Street			er, City or	Town, State, Zi	p Code)
and 2 lealth am 27 is			M. Salmon	(Daugh			Stringto			<u> </u>	ryland	21152
Pages 1 ment of H ant: If ite ury or otl			position ☑Cremation 3 ☐ 5 ☐ Other (Specify)		state	ans Fu	sition (Name of natory or other plac neral Cha	pel 23	oruary 2010	Fo		ll, Maryland
permit Depart Import any inj		21. Signature of Fu	ungral Service Licens	see /		Pe	Name and Address Name and Name and Na	ss of Facility Ematives 1 Road Tim	Funeral & onium, Mar	Cremat vland	tion Ctr., 21093	,P.A.
Physician		shock, or hea	the disease, or comp art failure. List only o (Final	lications that ca ne cause on ea	aused the deat	th. Do not ent			or respiratory a	rrest,		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	on C	a Due to (or as a consec	quence of):	(0)	n ce v			3	seurs h
Examiner	<u>_</u>	Sequentially list co	nditions,	b		uana of).						9 months
uted d ansit	Examiner	Sequentially list co- if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	arnediate erlying injury	Due to (or as a consec	quence or):						
		resulting in death)	Last	Due to (or as a consec	quence of):						
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ath certif ittending or use as	Physician/Me	IF FEMALE; 23b. Was deceden in the past 12 1 ☐ Yes 24 9 ☐ Unknown	months?		oirth 2 🗌 Feta ant at time of	al death 3	Ectopic pregnanc Other (specify)	у		2	3d. Date of deliv	very Day Year
uires that the de	by Ph	Part II. Other signi	ficant conditions co	ntributing to de	ath but not res	sulting in the u	nderlying cause give	en in Part I.				the cause of death?
w requir been si should I	eted		-				-			Yes 2		bably 4 Unknown
ding Physician: The law n. After this certificate has funeral director, page 2 s	Completed								24a. Was auto perfo 1 🗆 Yes		prior to or death?	opsy findings available ompletion of cause of 2 □No
rsiciar s certifi lirector	Be c	25. Was case refer examiner? 1 ☐ Yes 2 ☑	1 -	Hospital:	npatient 2	1 EB/Outpatier	nt 3 DOA Oth	or.	ath <i>(Check only o</i> Iome 5 22 esi		Other (Case	16.0
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tendir eath. tor: Af the fur	catic	2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not be				M 1 🗆	Yes 2 □ No				
tal or Atres after of al Directed in by	Certification:	4 Homicide	determined	1 28e. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, tarm, str	eet, factory, office		28f. Location (City or To		Number or Rui	al Route Number,
	Medical	29a. Certifier (Check only one)	CertifyIng Phy Medical Exam		asis of examina		n occurred at the tirvestigation, in my o					
To t With To t	Ž	29b. Signature and	title of certifie	law.	no		29c. Licens	e number Z å S Z S	7	29d. Date 2/2	e signed (Month)	, Day, Year)
<u></u>		30 Name and addr	ress of person who c	ompleted cause	e of death (Iter	m 23a) (Type,	PrintoXarle	0 50	BAGT.	mil	no	21204
Stat Registra		31. Date filed (Mon		010 32. 1	egistrar's Signa	A. A	backer	/			1	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 340 Year **Physician** McDonald 13 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gardens burtland Baltimore AKESVIILE, MID If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 95 Yrs. 6. Sex Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 M 2 □ F 214 40-5364 Director North Carolina Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r then "netural", or Items 23e or 28e-f show the Medical Examiner coust be notified at 1X Yes 2 No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21210 Funeral 1190 W. Northern Pkwy 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2☐No 1942 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other then ury or other traumatic event, Ibe M. Elementary/Secondary (0-12) College (1-4or 5+) principal Public Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charlie McDonald Rosa McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarina Nelson/sister 5300 Fernpark Ave.; Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State pernit. Page Department of Importent: If any injury or once. 4 ☑ Donation 5 ☐ Other (Specify) KFunera S ice Lice We lirector State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in ath) 040640 Physician Sale /Medical Examiner Due to (or as a contequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wirknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No of Vital To the Hospitel or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 🗌 Yes 2 □ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie ical within 24 ho

To the Fune
completely f 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day Matzdorff 2:40 PM Physician Virginia 18 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Seasons Hospice at Northwest Hospital Randallstown 8. Date of Birth (Month, Day, Year) June 28,1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F Months Days Hours 86 June 217-16-6407 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. vir. or natural barrelling and injury or other traumatic event, the Medical Exp. vir. or natural barrelling and injury or other traumatic event, the Medical Exp. vir. or natural barrelling and injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🛣 No Directo Woodlawn MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21207 5500 Lexington Road Apt. 109 **Funeral** 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Restaurant 0wner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Sikalis Pardaki Similis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 211 Westport Bay Drive Apt. 210 Glen Burnie,MD21061 Mrs Mary Cain / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Februar 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 22, 2010 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation | Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 MO1357 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death End-Stage COPD Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a I be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been sin r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 No ospital or Attending Physician; The hours after death. certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Thes pice Hospital: 1 ∐Yes 2 ☑/No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral d 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0057465 MS Rajapakel M. D

State

Registrar

31. Date filed (Month, Day, Year)

2835 Smith Av N.S. Rajapakse, M.D 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5-235, Baltimore, MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.507Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 6:54 AM 2010 Elizabeth Miller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Davs Hours Min. (Month, Day, Year) 11-12-1930 Director 218-26-2081 79 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? Funeral 7529 Baltimore Annapolis Blvd. 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Anne Arundel County Secretary School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental George De11 C. Helen Weckesser and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Mr. Kenneth Miller / Husband 7529 Baltimore Annapolis Blvd. Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c, Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 02-20-2010 Glen Burnie, MD 22. Name and Address of Facility 1 2nd Avenue SW Signature of Funeral Service Licenses Glen Burnie, MD Singleton Funeral & Cremation Services MOH21 Approximate Inter al Between e and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner معع Equaritally list our difference, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I ed by t signed by Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, cate has been signated by page 2 should by Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ည 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes Accident Investigation 6 Could not be Suicide
Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner; To the best of my knowledge, death accurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

and title of certifie

e and address of person who completed cause of death (Item 28a) (Type, Print)

32. Registrar's Signatur

29b. Signature

18508

1600 S. Crain How Sterob Gler Burniemo

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05072 1 - State Registra Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Shirley C. Myers 12:00PM **Physician** 2010 9 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Forrestville 7006 Beltz Dr. P.G. 9. Birthplace (State or Foreign Country) Mach If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Wash D.C 1 ☐ M 2 🛛 F 577-52-1671 75 Yrs. 6-5-1936 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Washington D.C. 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20032 U.S.A. 172 Darrington St. S.W. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy. Important: if Item 27 is marked othe any Injury or other treumatic event, 90ce. 17. Father's Name (First, Middle, Last) Be Minnie Bullock Alexander Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 Beltz Dr. Forrestville MD. 20747 19a. Informant's Name/Relationship (Type, Print) Harry Myers (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem, 1 Cem. 2-20-2010 Hyattsville MD. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licensee 13 Hunt 908 Kennedy St. N.W. Wash, D.C. Francy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiomyopathy Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherasclerosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Priysician /Medical **Examiner**

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r than "netural", or Items 23a or the Medical Examiner must be r

filed within 72 hours after

Il Hygiene.

Maryland 21215-0036

Baltimore,

Box 68760.

P.O. |

Records.

Division of Vital

Completed by Physician/Medical Be 2 Certification:

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The law requires that the death certificate be executed as use jo ed by the a Jas page 2 Physician: director, this After thi funeral of or Attending after death. the within 24 hours a To the Funerel [Hospitei pletely

State Registrar

24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 ₹ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Sons Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Home 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Nelson 6525 Belcrest RD. Hyattsville MD

32. Registrar's Signature

29c. License number MD15133 29d. Date signed (Month, Day, Year)

2-17-2010

29b. Signature and title of confiler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marie McLaughlin February 20 20TO Nancy 9:25 а м Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Timonium 314 E. Timonium Rd. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 96 Months Days Hours Min. Ja/10nt 12ay, Y 1914 Newntryork Director 216=05-2744 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Maryland baltimore 1 Yes 2 No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 314 E. Timonium Road 21093 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Spedalere Carmella Azzara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 E. Timonium Rd. Timonium, Maryland Lois Corts/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/24/2010|Carlisle, Pa. Cumberland Val.Mem 22. Name and Address of Facility Funeral Home: In204 21. Signature of Funer | Sewice Lie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CARDIOVASCICAR PERTENSIVE Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ENAL if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The raw required to the after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnanc in the past 12 months Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 la 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 6 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and ti 29c. License number 29d, Date signed (Month, Day, Year) UB Und

State

Registrar

7600 OSLER DRIVE SUMESOS TOWSON, MD ZIZOY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JOHN T. EUECIUS, H.D.

TR 33 300

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 21, 8:07 P 2010 February Lee Morris Nancy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air Lorien Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number Days **Funeral** Hours 1 ☐ M 2 🛛 F 26, 1934 Maryland Director 218-28-1641 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-1 ehow Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 21229 USA permit. Pages I and 2 should be filed within 72 hours after death v Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than 'naturel', or items 23a any lajury or other traumatic event, it is Medies is page. 1207 Elm Ridge Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes a 1 Never Married 2 Married 2 No 1 ☐ Yes 2√2 No Specify: by 3√Widowed 4 □ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 9 Sales Person 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William C. Cavey Mary E. Miller ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 502 Foster Branch Road, Joppa, Maryland 21085 Charlotte Krucger / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Remova from 9 tate 4 Dengition 5 Defer (Specify) Lakeview Memorial Park 2-25-10___ Sykesville, Maryland e of Funera McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · ACUTE CEREBROVASCULAR ACCIDENT **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) /sicien Box 68760, Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🐼 No 5 ☐ Other (specify) signed by the at o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CORONARY ARTERY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PERSPHERAL VASCULAR page 2 autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Tes 2 No After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of centifier 29c. License number jam 745344 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) ,622 S. UNION AVE, HAYRE DE GRACE SURESH DHANJAN 32. Degistrar's Signature 31. Date filed (Month, Day, Year) State FEB 23 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Deat Examiner AR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 2 M 2 ☐ F 4, 82 1928 West Virginia 233-42-0719 Jan. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director Harford Edgewood Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2036 Kenny Court 21040 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 □Yes 2XNo Specify ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) Steel Manufacturing Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Priscilla Graham Chester Robinson McKinney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2036 Kenny Court, Edgewood, Maryland, 21040 Patricia McKinney / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial / 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Office (Specify) Department of Important: If any Injury or once. Bel Air Memorial Gdn. 2/24/2010 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signat 1317 Cokesbury Road, Abingdon, Maryland 21009 aus d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. P. t1. Enter the discase, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final Sepsis disease or condition resulting in death) to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform ormed? 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 1 Natural

physician and s the burlal-trans been signed by should be detacl cate has by page 2 s Certification: To funeral illed in by the f

this certificate

After

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at

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Physician

/Medical

Examiner

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Records,

Division of Mital

To the Hospital or Attending Physician:

death.

within 24 hours a

completely

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work?

5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

20/2010

29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

lannan.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SONIA MANNAN, 500 UPPER CHESAPEAKE DR BELAIR, MD 21014

State Registrar

Medical

31. Date filed (Month, Day, Year)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

31 Date filed (Month, Day, Year) FEB 2 3 2010

ORIGINAL

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 7.8.20a c.22 per fh. gall 3.2 10 yr ygiene
Amend Item 24a per verb ., g900, 02/23/2010dhb, 31 Mental Hygiene
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Day Physician 454 David Means 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Specialty Hospital Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days 219-30-7634 72 **Director** June 17, South Carolina Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 USA 10 North Bend Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" once. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married black 1 ☐ Yes 2 🖾 No Specify: Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 home builder carpentry 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be David Means Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3816 Glengyle Ave.; Baltimore, MD 21215 Sherry Smith/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Orney (Specify) ☐ 11 ☐ State Greenmount Crematory 3-2-2010 Balto. Md. 22Carl Com Cor Douglass Funeral Service P.A. State Anatomy Board; 655 W. Paltimore Street 21. Signature of Funeral For Ronald ice Licensee S. Wade Dixector paitimore 21217 natemy Board; 655 Cullough St. 21201 re, Maryland 21201 23a. Park . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca Final disease or condition resulting in death) Aspiration **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner inderlying Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed signed by the attending physician and defected for use as the burial-transit Doro Division or Vital Records, P.O. Box 68760, Physician/Medical tension IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1/Dipatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 📉 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who of op ted cause of death (Item 23a) (Type, Print) Charles 601300th 21230 Baltimore mo 31. Date filed (Mo State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar Certificate of Death	,,	Reg. No.	
Physicia Medical Exami			2. Date of De Month	ath Day Year 15, 2010	3. Time of Death 1111 hrs
14		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location		4c. County of Death	1
Funeral		Northwest Hospital Randallstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	er 24Hrs. 8. Date of B	Baltimore Cou lirth (MM/DD/YYYY) 9. Bir	•
Director		220-66-5439 1 X M 2 F 65 Yrs. Months Days Hours	Min.	26,1944 Ger	untry)
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ne Maryland or 28a-f show any lied at once.	ģ	Tennessee Stewart Dover		40. 0:5 (1)	1 Yes 2 No
th the Mar 23a or 28s	Il Director			10g. Citizen of What Cou United Stat	-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican 1 Yes, 2 No 1 Yes, 2 No 1 Yes, 2 No 1 Yes, 2 No specify:	, Puerto Rican, etc.)	White, etc. געו	ican Indian, Black,
ours aft atural"	d b	or Dates:	kind of work done	Specify: VVI	
36 nin 72 h E. than "n dical E.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Freelance	use retired)	Self Em	ployed
21215-0036 ould be filed within 7 Mental Hygiene. marked other than re event, the Medica			's Name (First, Middle,	Maiden Surname)	
2121 uld be fi Mental marked	To Be		ina Wager	mber City or Town State	Zin Code)
MD 3 nd 2 shou alth and m 27 is 1		Karin Black/ Sister 145 Overlook Road	d Dover, T	Cennessee 37	058
Ore, ges I and of Heal If iten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Feb ^{Pate} 19, 2010	Baltimore,	
Baltimore, permit. Pages I an Important of Heal Important: If itel injury or other tr	ŀ	4 Donation 5 Other Specify: Metro Crematory 21. Signature of Funeral Service Ideensee 22. Name and Address of Facility			_
		Alice Iser 299 Frederick I	Road Balti	more, Maryla	and 21228
. ✓ Physician	ļ	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as can failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Attneroscierotic Cardiovascular Disease Due to (or as a consequence of):			
	je l	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
d d	Examine	Couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
760, ficate be executed g physician and the burial - transit	dical	d. UNPENDED AMENDED IF FEMALE: 23b. Was decreted pregnant in the	<u> </u>		
18760, rifficate being physicias the buri	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	c pregnancy	23d. Date of delivery	y Day Year
Box 687 e death certific the attending p	ysician	1 Yes 2 No 9 Unknown			j
, P.O. res that the signed by t	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa Wolf-Parkinson-White Syndrome; Asthma; Chronic Alcoholism		obacco use contribute to	the cause of death?
ords, I w requires is been sig	eted	Wolf-Falkinson-White Syndrome, Astima, Official Accordism	24a. Was	an 24b. Were au	topsy findings available
Division of Vital Records, P.O Ital or Attending Physician: The law requires that treated that death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	Completed	<u> </u>	auto perfo	ormed? death?	ompletion of cause of
Vital Rec ysician: The l his certificate h	å	25. Was case referred to medical 26. Place of Death examiner?			
n of Vi	<u>۽</u>	27 Manager of Death 289 Date of Injury 29h Time of Injury 29h Injury at West		Residence 6 Other	:
ision Attendin er death rector: A	atio	1 V Natural 5 Pending (Month, Day, Year) 1 Yes 2	No		
Division ospital or Attend hours after death hours after death neeral Director: y filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	c. 28f. Location (or Town, S	Street and Number or Ru State)	ral Route Number, City
	Medical C				
F, iv 5	Me			29d. Date signed (Mor	
^		30. Name and address of person who completed cause of death (Item 23a)		February 16, 201	0
2		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI	D 21201		
Sta Regista	ate rar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 per Fh g901 3/2/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dora J. Ohmstede 4:45 PM February Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7400 Milardo Drive Kingsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | Western | Days | 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🎖 F 83 Yrs. **Director** 212-22-6148 Maryland Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Baltimore Kingsville 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 7400 Milardo Drive 21087 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Completed by Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norman Disnev Catherine Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Sommers, Daughter 7400 Milardo Drive Kingsville, Maryland 21087 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 02/22/10 Baltimore, Maryland 21. Signature of Funeral Service License ²², Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opset and Death FAILVAR CONCESTIVE Physician/ MEANT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CONOMANY ANTENY DISEASE 3 425 Sequentially list conditions, Examine dury, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral inversid investing page 2 should be deteched for use as the bursal-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA, POSTHENPETIC 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ♠ No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State Registrar 9518-B

PUILADELPUTA AT.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

PARCAMENT, MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY Physician/ 00:30 AM CARMEN ORTIZ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ARUNDEL ANNE BURNIE WASHINGTON MEDICAL CENTE GLEN BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Jarmary D. Yel 940 Copperu 215-66-2558 70 **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1 🗌 Yes 2 🕱 No Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21122 7908 Oak Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gentiva Health Services traumatic event, the Nurse's Aide 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Severiana Magallanes Leopoldo Casas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7809 Oak Road, Pasadena, Maryland 21122 Francisco Ortiz (Husband) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Feb. 26, 2010 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funda Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Unmediate Cause (Final Physician/ METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner EVERE METAI Sague itfally flet conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury GASTRO INTESTINA physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f Unknown P.O. been signed by t should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 ☑ No Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 No No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) injury 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063564 2010 February 301 Hospital Washington Meetical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Kalpesh MD 21061 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _Month Year Physician cith Emerson 2:35 PM 2010 Chrun 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A 405 Mar If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 21, 1929 9. Birthplace *(State or Foreign Country)* Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 15 M 2 □ F 403-34-6080 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marchal Evander must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 🗓 No Director Maryland Anne Arundel Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 5613 Liberty Terrace 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: ⋛ White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) W R Grace Co. Chemical Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Eugene Orr Grace Eva Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Marie Orr (Wife) 5613 Liberty Terrace, Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 2/18/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, 237 East Patapsco Ave., Baltimore, Md. 21225-1856 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MINUTES disease or condition resulting in death) /Medical Examiner yo cardia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed physician and sthe burial-trans 'Ogal P.O. Box 68760 Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by page 2 should certificate director, Certification: To this After thi death. Medical

Hospital or Attending Physician: The n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu completely within 2 To the I

		1 Yes 2 No 3 Probably 4 Junknown				
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Ves 2 □ No 2				
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)				
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hon	ne 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death ↑ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year) Injury Work?	8d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.				

29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

no completed cause of death (Item 23a) (Type, Print) address of person

31. Date filed (Month, Day, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	aryland					lental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, La	not)		Cer	tificate of	Death	7		Reg. No. 2	010	05982
	Physicia	n/		,	~11					2. Date of De Month	Day	Year	3. Time of Death 1:20 A M
	Medic Examin		Ruth Lorrai 4a. Facility Name (if not institution, give		<u>e11</u>		4b. City, Town,	or Locatio	n of Death	Februa	1	2010 unty of Death	1:20 A
	Examin	01	3644 Elm Avenue				Baltir				1	,	
Т	Funeral		Social Security Number 6.		(In yrs. las		If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of Bir	th v. Year)	9. Birthp	olace (State or Foreign trv)
	Director		217-05-3201 Usual Residence of Decedent	- W 2 231	91	Yrs.				(Month, De 02/06/	/1919	Mary	land
	and show 1 at	ror	10a. State 10b. County		10c. City,	Town or Loc	ation					1	0d. Inside City Limits
	Maryl 28a-f otifie	Director	MD		Bal	timore	è						1 🛣 Yes 2 □ No
	h the Baord	al D	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Coun	try?
	th wit	Funeral	3644 Elm Avenue	12. Was Decedent E	ivor in II C	112 1/	212		Origin? (Cno.	oifu Voo or No		U.S.A.	
တ	er dea or ite niner	by Fi	11. Marital Status1 Never Married2 Married	Armed Forces?		lf. If	las Decedent of Yes, specify Cu	ban, Mexic	an, Puerto I	Rican, etc.)		Race - Americ Black, White, e	
ğ	ırs aftı ural", IExai	ted t	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 💢 N	No Speci	fy:		Spec	^{cify:} Whi	te
<u>5</u>	72 hou " nat i edica	Completed	15. Decedent's (Specify only highest g			(Give k	ent's Usual Occ ind of work don	e during m	ost of workii	ng	16b. Kind o	of Business Inc	dustry
12	ithin iene.	Con	Elementary/Seconday (0-12)	College (1-4 or 5	+)	Labo) NOT use retire ⊃r⊖r	d)			 Manu	factur	ing
b	iled w of Hyg of he	Be	17. Father's Name (First, Middle, Last)					18. Mc	ther's Name	(First, Middle,	Maiden Surn	ame)	
ylar	ld be 1 Menta arked atic e	욘	William Pe	ddicord				Ru	th	Whit	e		
Maryland 21215-0036	shoul raumi		19a. Informant's Name/Relationship (,		i	g Address (Stree						Code)
e,	and 2 Health em 2;		Verna Fisher / 20a. Method of Disposition	Daugnter	Z0h Pl		Elm Ave	enue,		oate		on - City or To	sun State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 [4 🕱 Donation 5 ☐ Other (Spec		ce	metery, crem	atory or other p	,		3/2010		er, Ma	
altir	mit. P partme portar / injur		21. Signature of Funeral Service Lice		Audi		Name and Add						
m	permi Depar Impor any ir once.		150K+	-		7!	522 Cont	nelle	y Dr.,	Ste P	, Hano	ver, M	D 21076
			23a. Part 1. Enter the disease, shock, or heart failure. List only	nplications that caused one cause on each line	the death.	. Do not ente	r the mode of dy	ying, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
Shee	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)			TATI	CD	aga.	57	CANCE	12		Onset and Death
	Examiner		resulting in deathy	Due to (or as a	a conseque	ence of):							
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	ence of):							
	uted	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	C									
	e exection ar	al E)	resulting in death) Last	Due to (or as a	a conseque	ence of):							
90	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		d									
89	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d.	. Date of delive	ery
gox	death e atte	sicia	in the past 12 months?	1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)					Month	Day Year
P.O. Box 687	it the c I by th	Completed by Physician/Me	9 ☐ Unknown Part II. Other significant conditions		ut not recu	Iting in the u	adorlying eque	aivon in Dr	n+ 1	00- Did			a course of death?
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ğ	requii been should	lete	DEM ENITA							24a. Was	-		osy findings available
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a F	ian: Ti rtificat ctor, p	Be C	25. Was case referred to medical examiner?	li .			26.	Place of D	eath (Check	1 ☐ Yes only one)	2 No	I L tes	2 14 110
<u>z</u>	hysic this ce	은	1 Yes 2 No			R/Outpatien	t 3 🗆 DOA		Nursing Ho	me 5 Resi	dence 6 🗆 (Other (Specify,)
n of	ding F h. After 1 funera	ate:	27. Manner of Death Natural 5 Pending Accident Investigation	28a. Date of injur (Month, Day	y , Year)	28b. Time of injury		iury at ork? □ Yes 2	_	28d. Describe l	now injury occ	curred	
Sio	Attender deat cotor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of Inju		ne, farm, stre						mber or Rural	Route Number,
Division of Vital Records,	tal or rs afte al Dire		- I romodo dotemno	building, etc	. (Specify)					City or Tox	vn, State)		ļ
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	o the lithin 2 the louding the louding	Me	only one) 3 Certifying Nu 29b. Signature and attle of certifier	rse Practioner: To the I	best of my	knowledge, d		the time, d		e, and due to th		d manner as sta gned (Month, L	
	⊬ s ⊨ ŏ		· All	& M.	D		1510	972	_		Fek	22	2010
	7		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type, P	rint)	-					
			RICHARD LA 31. Date filed (Month, Day, Year)	M hoem		670	L N. G	HARL	es St	- ISAI	TIMO	y N	2010
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	rs signatu	ire	has	Pall					
				THE PURES	17 . A B. C. A.	00. 1 12	PRICKARS	14.77					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cobruge Physician/ Surapol Prasertratna 2004 3019 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** tone Arundel alti more Washing ton medical Cente If Under 24 Hrs. Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Hours Min. July 5, 1944 Thailand 65 Director 215-70-3584 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Glen Burnie Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 359 Gatewater Court, Unit 301 21060 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Specify: Asian 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineering Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chareon Prasertratna Naree Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 Gatewater Court, Unit 301 Glen Burnie, MD 21060 Prima Prasertrat, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Metro Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastatic Physician/ Bladder CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Elter onderlying Cause (Disease or injury Due to (or as a consequence of): Exami physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown g Unknown P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director. After this certificate has E completed filled in by the funeral director, page 2 s

State

Registrar

29a. Certifier

(Check

only one)

3 [

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical Center

Mn

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2027415

February 21,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 2 Go Month Feb. 200 AY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Memorial land Raltimore 30-3652 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔃 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Ves 2 No Marylar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5614 ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates : If item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) iit. Page 1 and 2 should be lited artment of Health and Mental Hygiene. 16b. Kind of Business Industry (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College (1-4 or 5+) Paren Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ 19a. Informant's Name/Relationship (Type, Print) dangeter 19b. Mailing Address (Street and No Hettitord-Watson 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State oemetery, crematory or other Department of Important; If any injury or 4 Donation 5 Dother (Specify) Signature of Funeral Service Licensee evi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pproximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PINATONY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine ute resol been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last mersinain Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by loiges Blenocorcinomo To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 131 res unsion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Riabeles After this certificate 1 Yes 2 XNo Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 🗆 Pending injury Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director, 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 12203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mary and see Bollo, ml 2(218 32. Registrar's Si State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Social Ac. County of Death Physician /Medical aregor)am ES D:al AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) 1an. 31, 1979 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□F Days Virginia 31 228-21-6408 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show aţ 1 ☐ Yes 2 🙀 No notified Director Virginia Frederick Winchester 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö Examiner must be 23a 114 Coolfront Lane 22602 U.S.A. Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: 1 Yes 2 No Specify. \$ Specify: 3 Widowed 4 Divorced White 'natural", Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than Sales Manager Auto Dealership the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked James Gregory Poe, Sr. Ruth Ellen Campbell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau 114 Coolfront La., Winchester, VA 22602 Nicole Lynn Poe (Wife) 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation Metropolitan Crematory 2/21/10 Alexandria, VA 5 Other (Specify), 22. Name and Address of Facility
Royston Funeral Home 21. Signature of Funeral Service Licens 102 E. Washington St., Middleburg, VA une 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardio pulmmany disease or condition resulting in death) /Medical Examiner acidos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ATIC burial-trar Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 No be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 2 No 1 Tyes 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autops has 1 Yes 2 🗌 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury this the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation After Natural 2 Accident or Attending s after death. 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide Cify or Town, State) 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of corpifier 20,2010 February av 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Registrar's Signature 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death 7.00 A M **Physician** Year earre Mother /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner cane Tousin hanve Boltimue. Towson Marylann If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**№** M 2□ F Months Days Hours Min. Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 ☑ No Himore owson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with USA 21286 0901 Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 7 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT, use retired) Elementary/Secondary (0-12) College (1-4or 5+) rrectiona 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glady Sherwood t of Health Owing 5 Mills, MD 21117 item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or permit. Pages
Department of
Important: If its
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3altimore 4 ☐ Donation 5 ☐ Other (Specify) 23-2010 22. Name and Address of Facility Quem C. Greene Funeral Services 21. Signature of Funeral Service Licensee Kandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage MOOTH **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Stre and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 2 □ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manney Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1)006521 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tommy Adel Ibrahun, MD 5601 Loch Raven Blvd. Baltimore, MD 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	e of Maryland /		rtment of H Fificate of L			liene eg. No2	010	05087
	Physicia	n an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and	number)	Т	4b. City, Town, or	Location of Death	rebrua		ZOIO nty of Death	4,121
)	Examin		Augsbury Lutheran Hom			Baltin				1timore	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ₹	7. Age (In yrs. last t	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 21	, Year)	Coun	lace (State or Foreign try) yland
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, To						1	0d. Inside City Limits
	e Man ta-f sh tified	ctor	MD Baltimore	Ва	ltimo						1 ☐ Yes 2X No
	with th	Director	10e. Street and Number	. 077		10f. Zip Code		,	I0g. Citizen i USA	of What Coun	try?
	ns 234	Funeral		Decedent Ever in U.S.	13. W	21207 las Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		Race - Americ	
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 1 1 If Ye	ed Forces? Yes 2 No s, Give or Dates:		Yes, specify Cuba		rican, etc.)		Black, White, ecify: whi	
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Maryland 21215-0036	2 should be filed and Mental Hygi Is marked other aumatic event, t	2	Harry Conrad George 19a. Informant's Name/Relationship (Type. Print	9 1	9h Mailin	a Address (Street	AIIIIA AIII and Number or Rui	alia Bo		wn. State. Zip	Code)
	and 2 sho saith and n 27 is ma		Janet Dukehart/daught		1017	4 Tracey	Beth Ct;	Ellico	tt Cit	y, MD	21042
Baltimore,	oth Ter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☑ Donation 5 ☐ Office (Specify)	from State	of Dispos etery, crem	sition (Name of natory or other place	ce)	Date	20c. Location	on - City or To	own, State
Balti	permit. Page Department of Important: If any Injury or once.		21. Signa III. Funeral Service Licensee Ronald S. Walte	Arector	St		omy Board	-		imore	Street
			23a. Part I. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. De on each line.	o not ente	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	id Stage 1	Liver	- Diseas	2				
	/Medical Examiner		Immediate Pause (Final disease or or dition resulting in death) a. End State Liver Disease Due to (or as a confe quence of): Metastatic Breast Cancer								
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68760,	icate be executed physician and s the burial-transit	edical E	d								
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P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	es, outcome pf pregnancy Live birth 2 □ Fetal de Pregnant at time of death Unknown	ath 3	Ectopic pregnanc Other <i>(specify)</i>	у		23d.	Date of deliv Month	ery Day Year
	that the		Part II. Other significant conditions contributin	g to death but not resultin	g in the ur	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
ırds	w requires been sign should be	ed by						10	Yes 2∭ N	lo 3∏Pro	bably 4 □Unknown
eco	e law re has beo ge 2 sho	Completed						24a. Was auto	osv	4b. Were auto prior to co death?	opsy findings available impletion of cause of
Division or Vital Records,			05.114				00 Bi i B	1□ Yes	rmed? 2X No	1 ☐ Yes	2 □ No
!	ysiciar s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER	/Outpatien	t 3 DOA Oti	26. Place of Dea her: 4 ☐ Nursing H	iome 5 ☐ Resi		Other (Speci	ASSISTED
n or	ng Phy fter thi	T:uc		Date of Injury (Month, Day Year) 28	Bb. Time of Injury	Wo		28d. Describe	how injury or	ccurred	0
Siol	tendii leath. tor: A	catic	2 Accident investigation 3 Suicide 6 Could not be	Place of injury - At home	farm str		Yes 2□No	28f Location (Street and N	lumber or Rut	al Route Number.
Ω	after c after c Direc d in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route In City or Town, State)								
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: Or an	To the best of my knowle the basis of examination manner stated.	edge, deatl	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			-	se number			igned (Month	
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			30. Name and address of person who complete	1835 Smith	. Ave	nae Su	te 203]	Baltino	se, M	ld ziz	09
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	· La	N.S.			*		
	Regist	rar	FEB 23 2010 A	kaken p.	1900						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** (3:00 A M lennic Fels 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death, **Examiner** HARKERO Air TACOBS Bel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 215-01-8152 93 **Director** Oct. 26, 1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 841 Flintlock Drive USA 21015 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ Specify: 3 ☐Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 721 Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygie <u>Bookkeeper</u> Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gaetano (nmn) Mosca ပ Rose (nmn) Moresco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important; If item 27 is any injury or other trau Rose Lessner / Niece 841 Flintlcck Drive, Bel Air, Maryland, 21015
Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2/25/2010 Baltimore, Maryland 21. Signature of Funeral Servi Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Moltiple Mycloma Zman King /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. East of Jary, to Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Poly myalsin 24a. Was an certificate has 1 Yes 2 → 10 **Division or Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ALF Hospital: 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Hospital or Attending 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director; the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Band 5 707 MO Wendy 16/0052 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month 'м /Medical 2010 any 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 030:10 mor-Harbor ent 9. Birthplace (State or Foreign **Funeral** Months Days 1□M 2**X**F 0 Yrs Director Feb. 2010 Maryland N/A Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Burnie Glen 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 208 Baltimore Avenue death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian 11. Marital Status Black, White, etc. r than "natural", or Iter the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2X No Baltimore, Maryland 21215-0036 Specify: El Salvadorian Yes 2□ No ð 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) () N/A N/A other 1 7 is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cesar Ordonez Hilda Rivas P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Rivas/ Mother 208 Baltimore Avenue, Glen Burnie, Maryland 21061 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20с. Location - City or Town, State February 5, Department of I Important: If ite any Injury or of once, 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 2010 Metro Crematory, Inc. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facilit Cremation Society of Maryland, Inc. ‰Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Male prosencephily /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b rector, page 2 sl 24a. Was an autopsy 1 | Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No s after death.

I Director: / investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 64658 9/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William DASH 300 1 South Hopeier St Bultimo MD 21325 31. Date filed (Month, Day, Year) State Registrar

State Registrar 3 Harme and Todress of pe

31. Date filed (Month, Day, Year)

FEB 23 2010

DHMH 17 Rev 1/2001

who, completed cause of death (Item 23a) (Type, Print)

GTrim 32. Registrar's Signature

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MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** A^{M} 3:10 2/15/2010 EVELYN RIDLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHEVY CHASE MONTGOMERY MANOR CARE HEALTH SERVICES Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🙀 F 10/7/1935 Boykins, VA Director 74 230-46-2720 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20010 United States 3200 16th Street NW Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □ Yes 2 🔀 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inventory Management Tech. Library Congress 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Blowe Russell R. Ridley Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 14904 Ridge Farm Ct. Bowie, Maryland 20715 Russell R. Ridley Jr./ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)/ 2/20/2010 | Silver Spring, MD Gate of Heaven 21. Signature of Funeral Service Lice Fee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 701185 Parti. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a the burial as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 217 No for 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo 24a. Was an cate has t , page 2 s autopsy performed? 1□ Yes 2₽No certificate 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Certification: Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: In 24 hour.
The Funeral Director of the filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Medical Center Drive Suite 201 Rockville, Maryland 20850 Truong Bao

29c. License number

POG 57124

29d. Date signed (Month, Day, Year)

2115/10

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Bo, MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-Statest MAFy SA9+ D362A/12010 of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:03 AM 2d10 22 Marjorie Rankin February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea Feb 08 1 🗆 M 2 🕱 Country) United Kingdom 99 Director 1911 284-03-1901 Usual Residence of Decedent show 10c. City Town or Location **FT. Meyers** 10b. County Lee Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director FIorida 1 🗌 Yes 2 No Freeland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13577 Brynwood Lane ral", or items 23a Examiner must b Funeral 21053 33912 United Kingdom 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: 3. Widowed 4 □ Divorced "natural", White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alexander Howarth Lena Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hoeckel /Daughter 3521 Baker Schoolhouse Road Freeland, MD 21053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Feb Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Chesapeake Crematory 21. Signature of Funeral Service Licensee MO1585 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ሺ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 Sother (Specify) 2 👿 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) re and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla	and / Depa <i>Cen</i>	irtment of F tificate of D	lealth and N Death		giene 2 Reg. No.	010	05093			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	D =1	D:1			2. Date of Dea	ath Day	Year	3. Time of Death			
	Medic Examin		Thomas 4a. Facility Name (if not institution, give st	Robert reet and number)	Riley	4b. City, Town, or	Location of Death	Februa		2010	6:50 a. ^M			
-			Casey House 5. Social Security Number 6. Sex	7. Ago //p.ym	s. last birthday)	Rockvill	e If Under 24 Hrs.	8. Date of Birt		gomery				
	Funeral Director			XM 2 □ F 60	Yrs.	Months Days	Hours Min.	Dec . 2	7 , Year) 194	9. Birthp Count New	place (State or Foreign try) York			
	Maryland 28a-f show ptified at	Director	10a. State 10b. County MD Montgomer		City, Town or Loc ney	ation				10	0d. Inside City Limits 1 Yes 2 No			
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	urs after deatt ural", or item il Examiner π	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - America Black, White, e ecify: Whi	etc.			
Baltimore, Maryland 21215-0036	within 72 ho giene. er than "nat , the Medica	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Seconday (0-12)	cation e completed) College (1-4 or 5+)	(Give k	NOT use retired)	ation Juring most of work	ing		of Business Indo	•			
yland	id be filed Mental Hy arked oth	To Be	17. Father's Name <i>(First, Middle, Last)</i> James Walker Rile	У			18. Mother's Name Audrey			name)				
Mary id 2 should setth and N in 27 is ma		19a. Informant's Name/Relationship (Type Judith L. Riley		treet and Number or Rural Route Number, City or Town, State, Zip Code) rland Court, Olney, Maryland 20832										
timore	t. Page 1 a rtment of H rtant: If ite njury or ott		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 2010											
Ba	permi Depar Impor any ir		21. Sign tre of rankra Service Licensee M00982 22. Name and Address of Facility Rapp Funeral & Cremation Service Silver Spring, Maryland 20910											
	Physician,	0 2	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Metastatic Non Small Cell Lung Cancer Approximate Interval Between Onset and Death											
	Medical Examiner		resulting in death) Due to (or as a consequence of):											
	outed nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a conse	equence of):									
09	certificate be executed nding physician and use as the burial-transit	edical E	resulting in death) Last	Due to (or as a conse	equence of):									
289	certif nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ast 12 months? ast 12 months? 4 Pregnant at time of death 5 Other (specify) Month							ery Day Year			
Division of Vital Records, P.O. Box	iaw requires that the death as been signed by the atte s 2 should be detached for	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1											
Recor	The law recate has be page 2 sho	Completed						24a. Was a autop perfor 1 \(\simeg\) Yes	sy	4b. Were autop prior to con death? 1 \(\sum \) Yes	osy findings available inpletion of cause of			
ıtal	sician: certific lirector,	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No	ospital:		Othe	ace of Death (Check	,	- 74		Hospi oo			
on of \	nding Phy ath. After this funeral d		27. Manner of Death 1 💹 Natural 5 🗌 Pending 2 🗍 Accident Investigation	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at ? Yes 2 No	me 5 ∟ Resid 28d. Describe ho			поѕртсе			
DIVISIO	tal or Atte	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stree	treet, factory, office 28f. Location			ion (Street and Number or Rural Route Number, r Town, State)					
DIVISION Of VITAI HECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	the Hospitalin 24 hour the Funeral	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	ian: To the best of my kno r: On the basis of examinat Practioner: To the best of	tion and/or investig	gation, in my opinio	n, death occurred at	the time, date ar	nd place, and	due to the caus	se(s) and manner stated.			
	With		29b. Signature and title of certifier T - ICOUCLE	chou,	mi	29c. License	3748			gned <i>(Month, D</i> ary 18,				
	20V		30. Name and address of person who con Jocelyne T. Kouat	chou, M.D.	201 E.	int) Universi	ty Pkwy.	Baltimo	re, Ml	D 21218				
	Stat Registra	ır	31. Date filed (Month, Day, Year) FER 2 3 201	32. Registrar's Sign	sture A. A.	Ald I								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ February Esther Fisher Rossi 6:22 pvmMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice of Baltimore Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 214-12-1383 . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 TX F Months Hours Maryland Director D<u>ec.</u> 1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Lutherville Baltimore 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21093 20 Wendslow Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 9 þ 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2 X No Specify: 3 x Widowed 4 □ Divorced Specify: "natural" White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be tiled witten of Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Secretarial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Fisher Etta Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Wendslow Rd. Lutherville, MD 21093 Jay Rossi son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 20,2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CCully Polyniak Funeral Home 21. Signature of Funeral Service Licensee 237 E.Patapsco Ave.Balťimore,MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Briast Priysician/ anu disease or condition RWS Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events sician and burial-transit Possi. Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? 1 ☐ Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \cancel{X} Other (Specify) ျ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural e Hospina. n 24 hours after death. he Funeral Director: Aft 5 Pending Accident Investigation within 24 hours after des

To the Funeral Director

completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Juty CRNP 18,2010 12149194 Februar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 H. Charles. Towson, MD 31. Date filed (Month, Day, Year) FEB 23 20 32. Registrar's gnature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible AMEND ITEM#16a, perFH, G900, 2/23/2010 WS State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:00 AM February 17, 2010 William John Rairigh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5913 Kavon Ave. Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1.26 M 2 ☐ F 47 Director 218-72-8137 Oct 21, 1962 Maryland Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho 1. Yes 2 □ No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5913 Kavon Ave 21206 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite, any injury or other traumatic event, the Modical Exemina-1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 2 No Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Chef Resturant 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be George Richard Rairigh Nancy Unk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Rairigh /Wife 5913 Kavon Ave. Baltimore, MD 21206 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 2010 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mroric 4ears /Medical Due to (or s a consequence of) Examiner er Kens If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): the all ending physician hed for use as the buria Box 68760 Physician/Medical for use IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) Cluals (2010 21084 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3718 Sh Nossisu. 31. Date filed (Month, Day, Year) /32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 3:30 AM Tay 2010 Medical 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore, Mr Medical Center Mari Kand N/A 8. Date of Birth Aug. 15, 1954 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** India Days Months 1 🕱 M 2 🗌 Hours Director **075-74-467**0 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits Director 1 Tes 2 K No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18319 Lost Knife Circle Apt. 201 20886 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Asian Indian "natural" 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Restaurant Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joginder Singh Jagir Kaur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 18319 Lost Knife Circle, Apt 201 Montgurery Village, 20886 Page 1 and 2 Kulwinder Kaur Sangha/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 24 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final tension Drewno morax Physician/ disease or condition Medical resulting in death) Due to (or as on nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a g 🗌 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? this certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Certificate: To 1 X Inpatient 2 🗆 ER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident 24 hours after deat Funeral Director: 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in tity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. To the F 29b. Signature and title of certi 29c. License number Resident 2010 NP1-1063671105 tricia of death (Item 23 Prope, Print)
Medical Center, 22 Green Steet, Balknove MD 21201 30. Name and address of person who completed cause of death (Item 23

State Registrar A Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Clinton Matthew Simmons, Jr. February 2010 12:34a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Home For Hospice Denton Caroline 8. Date of Birth Month Day Ye April 25, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Months Days Hours Min. Director Maryland 212**-66-011**0 1954 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Caroline Federalsburg 10e. Street and Number 10g, Citizen of What Country? Funeral 4270 Nichols Road #3 21632 United States Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 X Married 72 hours after þ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Uidowed 4 Divorced Specify: White Completed Year or Dates : If item 27 is marked other than "nature or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Heavy Machinery Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clinton M. Simmons, Sr. Helen George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 4270 Nichols Road #3, Federalsburg, Maryland 21632 Patricia Simmons/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 😾 Cremation 3 🗆 Removal from State 02/19/10 4 Donation 5 Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) year Comontas Medical Due to (or at a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam ng physician and as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be attending p for use as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 2 🗌 No ed by the a detached f Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be c 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident
Suicide 1 Yes 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one)

State Registrar 29b. Signature and title of certifier

Mary S. DeShields

31. Date filed (Month Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c, License number

401 Purdy Street Suite 101 Easton, Maryland 21601

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 26 per verb., g900-02/23/2010dhb Reg. No. 1 - For State Registrar Reg. No. 3-Time of Death 1. Decedent's Name (First, Middle, Las 2. Date of Death Day Year **Physician** 23:05PM bernard ebeuan 7/1/2010 /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3 ALTIMORE AINT AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 78 Yrs. 8. Date of Birth (Month, Day Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 249-40-6820 1 XM 2□ F Months Days Hours Director Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "content to the traumatic event t 10d. Inside City Limits 10a. State 10b. County Director MD timore 1 **Y**es 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 15A ensington Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐Yes 2 No Specify 3 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Secondary (0-12) College (1-4or 5+) Element 18. Mother's Name (First, Middle, Maiden Surname) (First, Middle, Last, tnnie iones 4216 Kensington Ka Place of Disposition (N cemetery, crematory of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn, MD 2-20-10 of Funeral Service Lie 21. Sign tt Sisi Balto. 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each it. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia Unllugum. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Day Month Year 5 ☐ Other (specify) o peu 9 Unknown ed by t s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page ; The perform Vital 2 1No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 1 Inpatient 2 ER/Outpatient 3 4 Medical Certification: To nours after death,
neral Director: After this
v filled in by the funeral di o 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 🗀 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and time of 29d. Date signed (Month, Day, Year) uno South Cuton Avenue, Gaint Agres Hospital, Bultimere, Meryland Rattavi

Registrar DHMH 17 Rev 1/2001

State

23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2 0 1 0 ear Feb 20 Donald James Staub 4:40A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Westminster Carroll 9. Birthplace (State or Foreign Country)
MD 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 **X** M 2 □ F Days Min. Months Hours 216-16-5064 Yrs Director 89 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland by Funeral Director must be notified Carroll 1 ☐ Yes 2 🔀 No MD Westminster 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 23a 8 Valley Bend Rd. 21157 USA or items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give 3 NVidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Graphics Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Charles F. Staub Effie Mae Smith should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra James Staub - son 8 Valley Bend Rd. Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State South Carroll Crem 2-21-10 Winfield, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home Signature of Juneral Service Lic fromes 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to for as a consequence of If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 🎝 No 3 🗌 Probably 4 🗌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 \square Residence 6 \square Other (Specify, 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

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Rd. Wistminster MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SNYDER Physician/ Month Februar 07:39 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 11 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Hours Min. Year Director 213-34-2658 71 1938 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ha notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Lincoln Ave., S.W. 21061 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Wetzel Gertrude Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Snyder / Husband 203 Lincoln Ave., S.W., Glen Burnie, Maryland 21061 Date 20 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donarion 5 ☐ Other (Specify) Feb. 2010 Metro Crematory, Inc. Catonsville, Maryland Name and Address of Facility Lrkley-Ruddick Funeral Home, P.A. 21 Crain Hwy., S.E., Glen Burnie, . Sigr ce License 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ANCER Physician disease or condition resulting in death) months Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death ☐ Other (specify) 2 \square No s been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♠No 24a, Was an certificate has autopsy performed Yes 2 page 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature a 29d. Date signed (Month, D0058779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar KASAMON

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HOSPITAL

Glen Burnic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2010 1:40 February 5, Α Carlton Franklin Swart 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) College View Center Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Days March 26, 1943 Virginia 225-52-7409 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 ☐ No Virginia Loudoun Aldie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 24503 Lenah Road 20105 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self-Employed Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Webley Benjamin Franklin Swart, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Dry Mill Rd. SW Leesburg, VA 20175 Cheryl Kirkpatrick (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Buriat ¬ □ Cremation 3 □ Removal from State 2/27/10 Union Cemetery 5 ☐ Other (Specify) Leesburg, VA 4 Denation 22. Name and Address of Facility Colonial Funeral Home of Leesburg 21. Signature of Funeral Service License 201 Edwards Ferry Rd. N.E. Leesburg. VA 20176 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Perepheral Arterial Disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4K Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation

Physician /Medical Examiner certificate be executed

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show e notified at

"natural", or items 23a or dical Examiner must be r

filed within 72 hours after death with the Hygiene.

12 should be filed within: , ...
th and Mental Hygiene.
27 is marked other than "natural"

Jefe,
Jermit. Pages 1 and 2.
Department of Health an Important: if item 27 any Injury or 2.

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

Director

Funeral

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Completed

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funeral director, After t Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fu death.

Physician/Medical 2 Completed Be P Certification: Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Examiner

To the Hospital or within 24 hours af To the Funeral D

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D60417

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

February 6, 2010

Hemen Shah, MD 65C Thomas Johnson Dr., Frederick, MD 21702

6 Could not be determined

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Francis Sands Jr. 2010 2246 PM 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimor 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral 1**X□ M 2 □ F Days Hours March 29 214-24-7372 82 Yrs Director Marvland Usual Residence of Decedent 10a. State 10h County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Forrest Hill Harford Md. 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 USA 1117 Bernadette Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, vvas Decedent Ever Armed Forces? 1 🔀 Yes 2 🗌 No If Yes, Give Year or Dates. Black, White, etc. þ 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working College (1-4 or 5+) life. DO NOT use retired) Elementary/Seconday (0-12) 12 years Salesman Insurance years years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked William F. Sands Sr. Catherine Blair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 1117 Bernadette Drive, Forrest Hill, Md. 21050 Linda Sands Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State February Oak Lawn Cemetery Dundalk, Maryland 4 Donation 5 Other (Specify) 201⁰ Inature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease or shock, or heart failure. List or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroschopic Cardinvascular Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown Heart Failure 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No rcholesterol emia Director: After this certificate Yes To the Hospital or Attending Physician: ' within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d, Date signed (Month, Day, Year) D0056092 . Mann, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar na Mann

31. Date filed (Month. Dav. Year)

32. Registrar's Signature

,9000 Franklin Sovare DR. Baltimore, MD.

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Phys Me	iciar edic	1/	State Registrar 1. Decedent's Name (First, Middle, Last)	STANL	w	Cen	tificate	of D	Death_		2. Date o	f Death	Day 12	Year 201	3. Time of Death 8:35 p M	
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2 should be filed very should be filed very should be filed very 27 is marked other traumatic event.	mano evenit	욘	17. Father's Name (First, Middle, Last) UT James Hilbert Sta 19a Informant's Name/Relationship (Fige	100	h Albilio	a Addrosov	(Street 3	E	mma	e (First, Mic Pauli	ne S	tanle	_y			
and 2	ity of ourer trad	116	19a. Informant's Name/Relationship (Fige. Denise Stanley Da Charlestown Retirement 20a. Method of Disposition 1 □ Burlal 2 □ Cremation 3 □ Rep 4 □ Donation 5 ★ Other (Specify) 1	noval from State	20b. Place of	of Dispos	9 Wood Maide Sition (Name natory or oth	e of			Cate				70 21228 Town, State	
permit. Page 1 a Department of I Important: If ite	once,		21. Signature of Funeral Service Licensee and I d S War 23a. Part 1. Enter the disease, or complications of the shock, or heart failure. List only one c	e rec	the death. Do	lва	1timo	re,	Mary	land	2120	1	Balt:	imore	Approximate Interval Between	
death certificate be executed The attending physician and ed for use as the burial-transit		lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fram, being the immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last d.	consequence consequence	ot):	di	en	rest	la							
that the death certificate be eled by the attending physicia detached for use as the buri			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	of pregnancy 2 Setal dear time of death	etal death 3 Ectopic pregnancy								ate of de	livery Day Year		
		Completed by Ph	Part II. Other significant conditions contri	ut not resulting						23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy find			robably 4 Unknow			
The lay		a B	25. Was case referred to medical examiner? 1 Yes 2 100 Hos	pital:				Othe	ace of Dea	_	1 🗆 k only one)	autopsy performe Yes 2	→NO	death?	completion of cause of	
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To the Hospital or Attendition within 24 hours after death. To the Funeral Director, A completed filled in by the fu		Medical	(Check 2 Medical Examiner:	On the basis of ex	camination and/ pest of my know	or invest	tigation, in m death occurr 29c.	ny opinio ed at the License	on, death o e time, date e number	ccurred a e and plac	t the time, o	ue to the cause(s) and manner as stated. time, date and place, and due to the cause(s) and manner st nd due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)				
	Stat istra	9	30. Name and address of person who com The state of the	7/	eath (Item 23a)		Pript) Len		lio	ne	la	n p	, C	ali	surrelle.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per Dyn C900 /2/23/2010 JH State of Maryland /Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:40 P 2010 /Medical 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Memorial Hospital Garrett 0akland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Maryland Director March 25, 1924 220-12-6348 85 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD Garrett Director 0akland 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 Mary Drive 21550 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Leo Reithmuller Gertrude Rosina Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health ar Important: If Item 27 is any Injury or other trau once. Mary Ann Varella/daughter 5306 Wendy Rd; Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Funeral Se ROH3 Ld 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street S. Wade Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Physician acute disease or condition resulting in death) Due to (or as a consequ for of) /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death signed by the a d be detached for 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably Unknown
 page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes ဥ 2 ER/Outpatient 3 DOA After this 27. Manger of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: the 1 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide

State

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only

29b. Signal of and title of certifier

Margaret A. Kaiser

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrary Signal

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

13079 Garrett Highway Oakland, MD 21550

29c. License number

29d. Date signed (Month, Day, Year) -16-2010

10-01502 LaTonya Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle Last) Physician/ Month Day February 19, 2010 0821 hrs 'ical Examiner Ionya hane 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** St. Agnes Hospital of Birth (MM/DD/YYYY 9 Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date 5. Social Security Number 6. Sex **Funeral** Months Country) Director 214 Yrs 2 **X**F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Ob. County 1 Yes 2 No more Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Num 21207 1328 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married 1 Yes Divorced If Yes, Give Year 1 Yes 2 No specify: If item 27 is marked other than "natural", ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the Medical ath nagel 18 Mother's Name (First, Middle Be mber or Rural Route Number, City or Town, State, Zip Code) Wother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemete 2 Cremation 3 or other Voudiaun orraine ark Donation 5 Other Specify 22. me and Address of ignature of Funeral Service Litens 5151 Ba eto Approximate Interval 23a, Part I. E ter the disease, or complications that caused the death. Do not enter **Physician** Between Onset and failure. List only one cause on each line Death /Medical Cardiomegaly Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit cal AMENDED 23a,27 per me g901 3-25-10 vt W UNPENDED ted by the attending physician detached for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown ģ ۵ page 2 should be Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed 1 ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Vital Be Other₄ examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other this 1 V Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ŏ After 27. Manner of Death Certification 1 X Natural 1 Yes 2 No Division Pending Investigation Accident 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State) (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital or Attending Physician: To the Hospital or Attendin within 24 hours after death
To the Funeral Director: A completely filled in by the fur

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

31. Date filed (Month Day, Year) FEB 23 State Registrar

Margarita Korell MD

32 Raistrar's Signature ORIGINAL February 20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 WIIAM 1:36 AM eph Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6037 Majors Howard Lane Apt <u>Columbia</u> Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **⊠**M 2 □ F Months Min. Hours (Month, Day, Year) Aug 10, 56 Country) Maryland **Director** Unk 195B Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 23a or 28a-f sho important If item 27 is marked than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 XNo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Apt. 21045 United States 6037 Majors Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒-No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Class Produce 8 Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Unk Schultz Cecelia Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brianne Schultz /Daughter 6037 Majors Lane Apt. 5 Columbia, MD 21045 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 17 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 Signature of Funeral Service Licensee 22. Nacremade responsible Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONDNMY Physician/ disease or condition Medical resulting in death) Due to (or as a consumence of). Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (prias a consequence of) bunial-transit nidemin Cause (Disease or iinjury that initiated events and (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? cate has been signed by the atterpage 2 should be detached for Month Day Year Pregnant at time of death Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1. Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending work 1 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 21044 LITTLE Popular

State Registrar 31. Date filed (Month Day Year)

DIBURN

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1:25 PM Donald Paul Skinner February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Lutherville Examiner 4c. County of Death Baltimore College Manor 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □**x**M 2 □ F (Month, Day, Year 10/3/1923 Davs Hours 218-18-6905 86 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 🗌 Yes 2 🏻 No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21286 1020 Hart Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give WW I I Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🙀 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Fed. Gov't Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel L. Underwood Howard P. Skinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important; If item 27 is 1020 Hart Road Towson, Maryland 21286 Eileen Skinner / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/27/2010 Timonium, Maryland Dulaney Valley Mem. 21. Signature of Eugeral Service Jic 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Dun to (ur as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown a | Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an cate has b autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 17 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ott Baltmore STHOMBERG 6701 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend, item 10b per fh 2903 5-20-10 ve State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Louis C. Smith February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 4 8 1 Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Year Mary Land 1 🖳 M 2 🗆 F Months Days Hours Min. Director 219-22-8248 Dec Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 🗌 Yes 2 🔀 No Md. Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2409 Lady Margaret Court 21111 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 🔀 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer <u>Engineering</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Α. Smith <u>Margaret Pulaski</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arleen Smith/ Wife <u> 2409 Lady Margaret Ct. Monkton, Md.</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Highview Mem. Gdns. 2-25-10 Fallston. Md 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Fuheral Service Ligensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ischinic Cardiomyopathu disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No detached g Unknown 9 Unknown P.O. ģ been signed be should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No ☐ Yes 2 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**X** No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 Februar 22,2610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chales, Towson, MD 6701

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) FEB 23 2010 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 08/7 Februare 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cente Baltimore n/a Medical Johns Hopkins Bayview If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye October 22, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** Min. Months Days Hours 1□M 2XF 213-34-0429 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in "Medical Erair her rust be mittle of once. 1 XYes 2 No MD n/a Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21230 600 Light Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔣 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 0 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Mill Leroy Parks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 969 Joshua Tree Ct. Owings Mills, MD 21117 Dean Schultz 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State February 22, 2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Fune al Service 237 East Patapsco Ave. Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Minutes **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of) **Examiner** eumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed cell Mercel burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 3 🗌 Ectopic pregnancy Month Day 5 Other (specify) signed by the signed for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy performed? Yes 2 XNo 2 No 1 ☐ Yes 1 ☐ Yes .: After this certifica e funeral director, p 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 23 2010

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 23 2010

32. Registrar

State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SHAFFER SCANLON 1656 M 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital center Westminster 1 If Under 1 Year | If Under 24 Hrs. Carroll 0 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours 1 □ M 2 🖾 F 442-32-7765 June 25, 76 Director 1933 Michigan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r items 23a or 28a-f shov iner must be notified at MD Carroll Eldersburg 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7200 3rd Ave; #C119 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2€ Married Baltimore, Maryland 21215-0036 ō white 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Frederick County Elementary/Secondary (0-12) than of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Item M College (1-4or 5+) child support investigator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles James Scanlon Beatrice Augusta Rideout ပ 19a. Informant's Name/Relationship (Type. Print)
Charles 0. Shaffer/husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 3rd Ave; #C119; Eldersburg, MD 21784 Department of Health a Important: If item 27 Is any Injury or other trau once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 21. Signature Kona S. Wade State Anatomy Board; 655 W. Baltimore Street Director Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) RESPIRATORY Physician 3 decue /Medical Due to (or as a consequence of): Examiner Lmonth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner 24CARS The law requires that the death certificate be executed HORFICSIENOSIO attending physician and for use as the burial-tran Due to (or as a consequence of) of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Charnic Atrice Pibrillation 13NOME Recept 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown beach intection venau 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has all director, page 2 s autopsy performed wound intection ex eqquance be the 1 ☐Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Division 1 🔁 Natural 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9/2010 031660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAPER Avence westminister manches rtomas 391 (SALVIU 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Day, Anthony Nathaniel Thompson 2010 8:48 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Cheverly PG 5. Social Security Number 8. Date of Birth (Month, Day, Year) 06/29/1952 9. Birthplace (State or Foreign Country) Washington, DC If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Days Hours 1 € M 2 □ F 577-70-7144 47 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MO PG Suitland 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3374 Curtis Drive #102 20746 USA or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or 1**X** Yes 2 ☑No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black leted 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Supervisor Federal Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence W. Thompson, Sr. Dorothea Roland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Almetrice D. Brown - Sister 4009 Oaklawn Road; Ft. Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🖼 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/02/2010 Cheltenham, MD Maryland Vet. Cem. 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 21. Sig. Turn of Funeral Service Licensee or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, toly one cause on each line. 23a. Par 1. Enter the disease, of shock or heart failure. List Interval Between Immediate Cause (Final Onset and Death h sician/ Anoxic brain disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atte in the past 12 months? Month Year 4 Pregnant at time of death 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabeter Meliting 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed Coronay onty 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No မ 1 Na Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar R

31. Date filed (Month, Day, Yea

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ROINTAN FARAMI FAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Registr

12150

's Signature

043446

Annapolis Road, Soite 312 Glenn Dale.

2.12.10

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:45 PM Taylor-McKoy Doretha FEB 14 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/15/1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2**X** F Months S.Carolina 212-34-0952 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 10a. State 1 X Yes 2 No Director N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 524 N. Charles St. Apt. 1010 21201 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) mentary/Secondary (0-12) College (1-4or 5+) 12th Grade Catholic Charities House Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ပ Frazier Taylor Ada Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3326 Fredrick Ave., Baltimore, MD 21229 Lorraine Lane(Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Cem 02/20/10 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee Jose in Address of Brown Jr. Funeral Home Milliano 2140 M. Fulton Ave., Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IRINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physlcian: The law requires that the death certificate be executed Box 68760, Due to (or as a consequence of): Physician/Medical the, attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and manner stated within 2. the 29d. Date signed (Month, Day, Year) 29c. License number Satish Kolore MD RES-000 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BOULEVARD BALTEMORE MD 21239 SATISH KABRA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Berlin Registrar

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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2010 Feb. Physician/ lemina 10:45 AM Medical 4a. Facility Name First institution, give street and number)
7402 Bricks worth C **Examiner** 4b. City Town, or Location of 4c. County of Death Baltimore Windsor 304 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth . Social Security Number 9. Birthplace (State or Foreign **Funeral** 3 (Month, Day, 191) 28 1 ▼M 2 □ F 8 Hours Director 28a-f shov 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director baltimore 1 🗌 Yes 2 🖼 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7402 Bric USA 21244 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 Mo Specify. Specify: Blac marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life PO NOT use retired) (Specify only highest grade completed) nited College (1-4 or 5+) Post Iruc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rison 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sment of Health a ant: If item 27 i laylor Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Frematory or other place) 1 Burial 2 Cremation 3 Removal from State 2-23-10 ark 4 ☐ Donation 5 ☐ Other (Specify) 21. Si Negure of Funeral Service Licensee lame and Address of Facility Greene Services Nat'I Ite. Ba 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final discore Physician/ disease or condition resulting in death) nea Medical Due to (or as a constant ce of): **Examiner** rabetes cass if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performed death? Hospital or Attending Physician: The 2 No 1 Tyes Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\to\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 0 Sician d address of person who completed cause of death (Item 23a) (Type, Print) 700 31. Date filed (Month, Day, Year) State FEB 23 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 20T0 6:59 P M Lisa Thomas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 E1kton Union Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (*Month, Day Year*) Aug 1, 1948 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Hours Delaware Director 213-52-5188 61 Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Cecil 1 Yes 2 No Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1655 Telegraph Road 21911 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) editor's assistant Cecil Whig Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robert Leonard Harding Helen Ewing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Thomas/husband 1655 Telegraph Rd; Rising Sun, Maryland 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signalure of Funeral Ser S. Wade, 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ s a consequence of disease or condition resulting in death) Medical Due to or Examiner Sequentially list or dittors, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 Z No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 ☐ Inpatient 2 Ø ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 🛮 Natural work' 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatur 29c. License number cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kenneth Ray Taylor State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Time of Death Physician/ Month 0230 hrs **Medical Examiner** Kenneth Ray Taylor Jr. January 30, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Marlboro Prince George's Croom Road at Mattaponi Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Country) D.C. Months Days Hours Director 578-06-1817 5-1-1981 1 X M 2 F 28 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a. State 10b. County P.G. Upper Marlboro 1 Yes 2 X No 23a or 28a-f show notified at once, MD. imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 15484 Mount Calvert Road 20772 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S 3. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes Black f Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 X No specify: ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Private 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kenneth Ray Taylor Sr. Veronica Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) Veronica Lewis (Mother) 15484 MT. Calvert RD. Upper Marlboro MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) Crem. Burial 2 X Cremation 3 Removal from State 2-17-2010 Riverdale MD. tment c Riverdale Park Donation 5 Other Specify: permit. 22. Name and Address of Facility 21. Signature of Funeral Service License Hunt Funeral Home 908 Kennedy St. N.W. Wash, D.C. 20011 /zeences 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line (Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and tran: sician/Medical ed by the attending physician detached for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been a director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed³ 1 🗸 Yes 1 ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 2 1 V Yes No 28a. Date of Injury After 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Driver of a police cruiser involved in a collision Jan 30, 2010 Division 1 Natural 0228 hrs e Funeral Director: #
etely filled in by the fi 1 Yes 2 ✔ No Pending with a fixed object 2 🗹 Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Croom Road and Mattaponi Road, Upper Marlboro, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 31, 2010 O.C.M.E. Duckall, MD 30 Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Yea 32. R gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 17, 2010 Physician/ CAROL ELIZABETH THOMPSON 7PM М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. June 19,1929 1 □ M 2√√ F Mary land Director 213-28-8516 80 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 1 ☐ Yes 2xx No Maryland Baltimore Towosn 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 1210 Boyce Avenue 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2XX Married þ Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of the second permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is meany injury or other. 2 Elizabeth McDonald Carroll McKenny Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Edward Thompson III 1210 Boyce Avenue Towson, Maryland 21204 Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State GreenMount Crematory or other February 20,2010 Baltimore, Maryland Donation 5 Other (Specify) nature of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ULMONA Physician/ MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at or Attending F after death. 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MS

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Thompson

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Registrar's Signature

ARLES ST. 8UTE 4105 BALTMOREIMO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Dorothy Mae Unverzagt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner KOSATTAL AGNUES BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year May 21, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 1937 216-36-3505 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be putified at once. 1 ☐ Yes 2 No Director Baltimore Maryland Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 2 Bray Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify. Specify: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Bus Driver Howard County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margie Tayler Kenneth Rice 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles R. Unverzagt, Husband 2 Bray Court Catonsville, Maryland 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Linthicum Chapel Cemetery | 02/23/10 Clarksville, Maryland 21. Signature of Funeral Service Licery MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PLBURAL STRUSTED MALIGNANT **Physician** /Medical Due to (or as a consequence of): 10 prentag LEUKEMIA (AML) **Examiner** MYBLOID ARM TES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and burial-trar Due to (or as a consequence of) ned by the attending physician detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown To the Funeral Director: After this certificale has been signed by completely filled in by the funeral director, p. ge 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

within 24 hours a the

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

CATON

AVE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar State Registrar Registrar															
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Weintral Baltimore, Mary	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur				11000	22.1	lame and	Address	of Facility	Ana	atomy G	ift	s Regi	str	У	
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ivisio	l or Atte after des Director	Certificate:	3 ☐ Suicide 4 ☐ Homicide	of Injury ng, etc. (3	- At home, f Specify)	farm, street	, factory,	office		2	28f. Location (S City or Tow			r Rural	Route Number,	_		
ì	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral discompleted filled in the filled filled in the filled fil	Medical	29a. Certifier 1 (Check 2	Certifying Phys Medical Exami	ner: On the basi	s of exar	mination and/	or investigation	ation, in m	opinion	, death oc	curred at t	the time, date a	and plac	e, and due to	the car	use(s) and manner stat	ted.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 2010 Wilkinson Kathleen Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore HOSpital Agnes N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 26, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 XF 1934 75 Yrs Pennsylvania 165-26-0331 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Windsor Mill Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7208 Chamberlain Road 21244 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after theath and Mental Hygiene. Heath and Mental Hygiene. em 27 Is marked other than "natural", or itei 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Claims Adjuster Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked of any injury or other traumatic ev Harold Edwin Wilkinson Cecilia V. Rooney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Levine/ Husband 7208 Chamberlain Road, Windsor Mill, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Pages 1 February 25. 1 ☐ Burial 2 XCremation 3 Removal from State Metro Crematory, Inc. 2010 Baltimore, Fally Ceaston 22. Name and Address of Facility MacNabb Funeral Home, P.A. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician week ab IVEV Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by The law requires bronchormumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an certificate 2 No 2□ No 1 Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury or Attending Division 1. Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident hours after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and Atte 29c, License number 29d. Date signed (Month, Day, Year)

15

CIKINGON

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Agnes

Avenue - Baltimore

M.D. Ph.D.

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	,	Cer	tificate of	Death	F	Reg. No.				
	Dhysisi		1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	2. Date of Death Day Year 3. Time of Death Month				
	Physicia /Medic		Warren	Е.		Wilson		02	17 201	.0 01:30 M			
	Examin	er	4a. Facility Name (If not institution, give Season s Hospi				r Location of Death dallstov	٧n	4c. County of I	Death Limore			
	Funeral Director			ex 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country) MD			
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Lo	cation				10d. Inside City Limits			
	Maryla -f sho	tor	MD NA			timore				1 X Yes 2 □ No			
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?				
	s 23a	eral	2811 Waldorf Av	V E	12.1		1215	poity Voc or No		American Indian,			
ယ္	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show digal Examiline Frant by notified at	Funeral	11. Marital Status 1 ☐ Never Married	Armed Forces? 1 ☐ Yes 2 📉 No			dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)					
003	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		i⊡Yes 2X∏No	Specify:			Black			
15	n 72 h "natu badica	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Busin	ess/Industry			
212	filed within Hygiene. other than '	Jul	12th grade	College (1-4or 5+) na	Sani	tation				Baltimore			
nd	2 should be filed within 7 h and Mental Hygiene. 7 is marked other than " raumatic event, the Med	Be	17. Father's Name (First, Middle, Last,						Maiden Surname)				
ryla	hould nd Mer marke matic	ဥ	Carlton Wilson 19a. Informant's Name/Relationship	Type. Print)	19b. Mailir	a Address (Street	Mary E. and Number or Rui		th Wilso er. City or Town. Sta				
ĭ Ma	1 and 2 s Health ar tem 27 is		Karen Wilson-W				f Ave,		-				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hadical Examinet" was be notified at once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	ace of Dispo metery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location - Cit	y or Town, State			
ţ <u>i</u>	it. Pag rtment rtant: njury e		4 ☐ Domation 5 ☐ Other (Specif	y) Kir			Park 2/3	23/10	Woodlaw	vn, Md			
Ва	perm Depa Impo any i	9	21. Signiture : Funeral Service Licer	Breta	4		ash Ave			1d 21215			
		2 30	23a. Part I. Enter the disease, or com shock, or heart failure. List only	one cause on each line.				or respiratory ar	rrest,	Approximate Interval Between Onset and Death			
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Esopha ge Due to (or as a conseque		arcinor	カタ						
7	Examiner			h	stice oi).								
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					l.			
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68760,	ertificate be executed ing physician and as the burial-transit	Medical		d									
39 x	certifica ding pl		IF FEMALE:	23c. If yes, outcome of pregnan	101				001 8-1	7.4-0			
O. Box	ires that the death cer signed by the attendir d be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fetal of Pregnant at time of de	death 3[Ectopic pregnand Other (specify)	су		23d. Date of Month				
σ.	s that the ned by detac	by Ph	Part II. Other significant conditions	contributing to death but not result	ting in the u	nderlying cause gi	en in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?			
ords	w require s been sig should b	ted b						1 🗆 \	/es 2 □ No 3	Probably 4 Unknown			
Division of Vital Records,	Attending Physician: The law requires that the death certificate be executed r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Completed					15111417	24a. Was autop perfo 1 □ Yes	rmed? pric	re autopsy findings available or to completion of cause of ath?]Yes 2 □ No			
Vita	sician certifi irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ E	B/Outpation	t all pos Oth	26. Place of Deather:			n-patient hospile			
οl	ig Phy ter this neral d	n: To	27. Manner of Death		28b. Time o Injury				now injury occurred				
sior	tendin eath. or: Af the fur	catic	1	n		M 1 =	lYes 2□No			2 (2)			
Divi	ਰ ਵੀ ਜ਼ੈਂ⊆	Certification: To	4 Homicide determined		ne, farm, str)	eet, factory, office		City or Tov		or Rural Route Number,			
	To the Hospital or Attending Physician: The law within Earherous after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best of my know miner: On the basis of examinati and manner stated.	rledge, deat on and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manr date and place, and	ner as stated. d due to the cause(s)			
	To th within To th	Me	29b. Signature and title of certifier	in abre Min.		29c. Licen			29d. Date signed (i				
				ipahse M·D·			00057465 2/17/10						
			30. Name and address of person who	completed cause of death (Item	23a) (Type,	Smith 7	Av., S- 2	03, 30	utimore	MD. 21209			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure	hadel							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 2010 **Physician** Month Jyo Woodson Mae /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Courtland Gardens Nursing Home Pikesville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 10 03 **Funeral** Birthplace (State or Foreign Country) Year) 1 M 2 F **Director** 38 71 248-60-5765 Usual Residence of Deceden SC the Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 □ No NΑ Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or Itama 23a or Examiner nust be 4033 Grantley Road 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Black 3 X Widowed 4 □ Divorced Specify: other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. othar than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4yrs Claim Adjuster Social Security Adm. 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H f ftem 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Anthony Hickman Rosa Hickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Derrick Woodson-Son 15402 Brinton Way, Bradywine, Md 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State P = 1 Burial 2 □ Cremation 3 □ Removal from State ŏ permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 3/2/10 Owings Mills, Md 21. Signature of Funeral Service Licensee March Funeral Home West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician - canin will disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ mes com Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 25 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Tursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation М Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Day, Year) ひんてるしょ aun' son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Below 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item loa per th g900 2-23-10 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:11 8 Day Physician/ Month Norma T. Williams 2010 рМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4047 Lyndale Avenue Baltimore N/A Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 X F Days Hours Min. (Month, Day **Director** 218-86-4907 71 MD Usual Residence of Decedent and Mental Hyglene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4047 Lyndale 21213 USA Avenue death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene. Sant: If item 27 is marked other than "natural", or Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer 10th grade A R A Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jefferson Handy Odrey Mackall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Shauntee N. Bryantdaughter 643 McKewin Balto, MD 21218 Avenue 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 2-24-2010 Balto, Greenmount Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 Ε. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Card Medical resulting in death) Examiner orongry Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? signed by the atte Month Day Year ☐ Pregnant at time of death☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy ours after death. eral Director: After this certificate h filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours Funeral Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретен within 24 h Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) MEDICAL DOCTUR FEB 12,2010 RES-000 BALTIMORE, MARYLAND 21287 address of person who completed cause of death (Item 23a) (Type, Print) TNES JOHNS HOPKINS HOSPITAL 6/10 NORTH WOLFE STREET

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per FH G901 3/12/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAM FEBRUARY WINEBRENER 2010 9:05 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HEALTH & REHAB CENTER HARFORD FOREST HILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Jumoth, 24, Yea9 4 2 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-40-3045 1 🔀 M 2 🗆 F Mary Tand 67 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Director Examiner must be notified 1 ☐ Yes 2 🛣 No Md. Harford Fallston ö 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 2650 Friendship Rd 21047 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0 þ Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. White "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Silvertop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William V. Winebrener, Sr. Catherine M. Engelmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Sterling Avenue Middle River. Md. 21220 Barbara Vincent Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Parkwood 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-23-2010 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Livensee 22. Name and Address of Facility Schimunek Funeral Home nie D 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any collecting to in the first cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dire to (unas a nonsiliquento of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown P.O. signed k d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpa this funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending 1 Natural n 24 hours after death.

The funeral Director: Af oldered filled in by the funeral filled in the funeral fun Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3229 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD - BEL AIR, MD. 21014 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Albert Wyatt, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death timore Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
Ju 19 29, 1921 If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Min. Maryland 220-05-7522 88 Yrs. **Director** Usual Residence of Decedent 28a-f shov 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Balto. Md. Overlea ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? þe ral", or items 23a Examiner must b Funeral 4601 Forest View Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1♣ Yes 2 ☐ No If Yes, Give Year or Dates. 1943—1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 XMarried White 1 Yes 2 No Specify: Specify "natural" 3 Widowed 4 Divorced Completed the Me ical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene.

27 is marked other than 's traumatic event, the Me $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Insurance Executive Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert A. Wyatt Regina K. Connolly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Capella DTR. High Button Court Nottingham, Md. 21236 other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood 2-23-2010 Parkville Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) **Medical** as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or/as this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending death. 1 Yes 2 No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person w

31. Date filed (Month, Day, Year)

auare

completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Leota F. Williams 9:55 A.^M 22, Feb. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Village Parkville Baltimore County Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🛛 F Months Days Hours 222-18-2948 Director 91 July 01,1918 New York Usual Residence of Decedent 10d Inside City Limits show 10a, State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination at the motthled at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Blvd. United States 21234 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married , o. 21215-0036 1 □ Yes 2 🛣 No Specify: þ Specify: White 3 ☐ Widowed 4 🖾 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Librarian Delaware Schools 06 and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Ford Mearl Barret Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Mr. Christopher Williams 4239 Four Mill Road Baltimore, Maryland 21236 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other: ltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 24, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 2010 Forest Hill, Maryland 21. Signature of Funeral Service Licensee (Jeffrey L. 22. Name and Address of Facility
Peaceful Alternatives Funeral & Crematicn Center, P.A.
2325 York Road Timonium, Maryland 21093 Gair, Sr.) Pan . H te the lisease, or on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or yone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissas or njury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Year Month Day 5 Other (specify) Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by Hyporknsive Cardiovascular Dixase 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 No 1 □ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 ☐ Yes Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death, To the Funeral Director: After Division 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R171944 CRAP DOSN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP MIN 8800 Walther Blvd, Parkville, MD 21234 G. Harrison Michaelle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Denve B. park Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2000 1232 AM Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore, MD Medical land If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗹 M 2 🗆 F Months Hours Min. Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Hits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces' Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 No 1 Yes : Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed la C Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be . Fa her's Name (First, Middle, 18 MAthe 19a. Informant's Name/Relationshib 19b. Mailing Address (Street and Numb Rural Route Number, City or Town, State, Zip Code) any injury or other Baltimore, Place of Disposition (Name of cerrletery, crematory or other 0a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it matory or other place Burial 2 Cremation Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silynaty e of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) nuncer Medical Due to (or as consequence of) Examiner Sequentially list conditions. Examine it dry leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or es e consequence of) physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed Yes 2 certificate ! Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No Hospital: မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

(Check

only one

29b. Signature and the

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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J. letron

EEB 23 2010

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

22 S. Greene St. Bathmore, MD 21201

952504573

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month ERTRUDE B. WATTS 11:07AM FEBRUARY 2010 19 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner BAUTIMORE MEDICALCENTER JOHNS HOPKINS BAYVIEW 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** r 21,1924 Months Days Hours Min 1 □ M 2 🔽 F 219-16-4422 85 Decembér **Director** Märyland Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Md. Baltimore Dundalk Director 1 ☐Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Centre Ave. 21222 USA Funeral death y 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examina any injury or other traumatic event, the Medical Examina once. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 TVNo þ Specify Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 years 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) William Henry Huber Emily L. Cushing ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Szymezak Son 61 Laurel Path Court, Nottingham, Md.21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cem. Middle River, Md. 4 □ Donation 5 □ Other (Specify) 27, 2010 21. Signature of Fun val Service Licenses 22. Name and Address of Facility Connelly Fune 7110 Sollers Funeral Home Of ers Point Road, P.A.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOGENIC **Physician** SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) UNKNOWN **Examiner** SEPSIS Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **2** No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral Hospital or Attending P 24 hours after death. Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

JENNIFER CHEN

FEB 23 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License number

RES-000

M.D. 4940 EASTERN A VENUE BAIJIMORE, MD

29d. Date signed (Month, Day, Year)

FEBRUARY

19,2010

Ernest Whipple 10-00996 UNK UNK

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State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar Certificate of Deal		_	2010	05130				
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Medical Exam	iner		Town, or Location of Deat	February 3,	, 2010 4c. County of Death	1230 H/S				
		3200 Whitman Drive Baltin			Baltimor	e				
Funeral Director		5. Social Security Numbeank 6. Sex 7. Age (In yrs. last birthday) If Unc	der 1 Year If Under 24Hr hs Days Hours Mir		(MM/DD/YYYY) 9. Birt Foreig Cou	hplace (State orunk n intry)				
		Usual Residence of Decedent								
w any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 No				
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens I ham a Mental Hygien I ham I ham a Mental Higher I ham what I filem 27 is marked other than "natural", or items 23a, or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? unk If Yes, special Yes 2 No	ent of Hispanic Origin? (S ify Cuban, Mexican, Puerto		14. Race - Americ White, etc.					
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876 tificate ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year				
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O. Bo at the de	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did toba	acco use contribute to t	ne cause of death?				
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Division of Vital Records, tal or Attending Physician: The law required and the death. After this certificate has been sited in by the funeral director, page 2 should be	Completed			24a. Was an autopsy		opsy findings available impletion of cause of				
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ViSic or Atte fler des directo	fica	3 V Suicide 6 Could get be 28e. Place of Injury - At home, farm, street, factory		28f. Location (Str	eet and Number or Run	al Route Number, City				
Dispital cours at filled filled	Certification:	4 Homicide determined (Specify) TOUTIGE ITT WOODS	i i	Herring	eet and Number or Rur. te) 3200 Whit Run Park)					
Division of Vital Records, P.O. Box 68760, within 24 hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the law requires that the funeral Directors After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.								
E 3 E 8	Me		c. License number]2	29d. Date signed (Mon	h, Day, Year)				
			O.C.M.E.		February 4, 2010					
	- 113	Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	Street, Baltimore, M	ID 21201						
	ate									
Regis		55B 23 2010 Down A. A.				4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 6:30 PM Monique ebruari 0105 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 04 Baltimore Sinai Hospital 0 If Under 24 Hrs. 8. Date of Birth
Hours Min. A (Month, Day, Year)
A OY I 21, 195 timore 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 M 2 W 218-74-7656 Director ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No altimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21216 airview 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 10 1 Yes 2 No Specify: "natural", 3 🗌 Widowed 4 🗆 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within emar 0 Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ toward Vans 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Honore omonique Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State Memour 4 Donation 5 Other (Specify) 21. Signature primeral Service Lice see aito MD 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medica Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury UNKVLOWE To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 morans?
1 Yes 2 No Month 1 Yes 2 U Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by potion 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed' erot 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 10 No Other: ဂ္ 1 Ninpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify filled in by the funeral 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge. Seath consider the time date and place, and due to the cause(s) and manner as attended. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 2010 Februar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Marina L Pratt MD, Singi Hospital of Baltimore, 2401 W. Belvedere Ave., Baltimore MD 21215 State Registrar

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10-01485 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Hannah Wheeling 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day February 18, 2010 Medical Examiner 0728 hrs Hannah Elizabeth Wheeling 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's 11001 Frank Tipett Road Upper Marlboro 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Months Days Hours Director 219-42-9252 CountryVirginia 1 M 2 X F 1944 65 June 25, Usual Residence of Decedent 10d. Inside City Limits iny 10a. State 10c. City, Town or Location 1 X Yes 2 No altimore, MD 21215-0036
mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.
portant: If item 27 is neared other than "natural", or items 23a or 28a-f show inty or other traumafic event, the Medicial Examiner must be notified at once. Maryland Harford Bel Air 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 這 207 E. Courtland Place 21014 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 2X No Yes Specify: White If Yes, Give Year 4 X Divorced 1 Yes 2 No specify: <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+Public Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenmore Howard Drasher Matilda Elizabeth Brandau ဥ 19a Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Catherine Rose / Daughter 96 Surrey Lane, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, Date crematory or other place) 1 Burial 2 XCremation 3 Removal from State 2/23/2010 Hilltop Service Corp. Towson, Maryland 4 Donation 5 Other Specify. 22. Name and Address of Facility
MCComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and Medical a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED **AMENDED** IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for uses as the burial - transit Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed

ş

Completed

Be

Certification:

Medical

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Yes 2 No 9 Unknown	9 Unknown									
Part II. Other significant conditions co	ntributing to death but not re	esulting in the underlying	ng cause given in Part I.		co use contribute to the cause of death?					
				1 24a. Was an	Probably 4 Unknown					
				autopsy performer Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No					
5. Was case referred to medical			26.Place of Death (Check	only one)						
examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other Scene										
7. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year) FOUND: Feb 18, 2010	28b. Time of Injury FOUND: 0703 hrs	28c. Injury at Work? 1 ✓ Yes 2 No	28d. Describe how Subject assaul						
3 Suicide 6 Could not be determined	28e. Place of Injury - At ho (Specify) Juvenile Do	ome, farm, street, facto etention Center	ry, office building, etc.	or Town, State	et and Number or Rural Route Number, City) ett Road, Upper Marlboro, MD					
ne) 2 Medical Examiner: Or	To the best of my knowledge the basis of examination and manner stated.	•		. ,	and manner as stated. place, and due to the cause(s)					

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001

State

OCME 2006

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

February 19, 2010

Death

10-01440	
Sally Ann	Waite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		- For State legistrar			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certi	ficate	of D	eath			J. T. T. F	Reg. No.				
Physician	1	Decedent's Name (First,		t)							1	2. Date of Dea	ath Day	Yea		3. Time of Deat	h
Medical Examine		Sally Ann Wa										February	17, 2	010		1447 hrs	
	1	4929 Goodnow R			i number)				City, Town, o Baltimore	r Location o	of Death			c.County o Balti	more	e	
Funeral Director		5. Social Security Number 041-42-8846	6. Se	x M 2X		in yrs. last 62	birthday	-	f Under 1 Yea Months Day		er 24Hrs. Min.	8. Date of B			Cou	place (State or ntry) 1011 - 1012 - 1013	Foreign NY
' any	-	Jsual Residence of Deced	ent			c. City, To		ocation		<u> </u>						10d. Inside City	Limits
Aaryland 28a-f show	<u> </u>		altimo	re		Balt	imo				_					1 X Yes 2	No
with the Maryland ns 23a or 28a-f she be notified at once		10e. Street and Number 4929 Goodnot	v Rd;	Apt 1	L			11	21206					izen of Wh	at Count	ry?	
r death	by runeral	11. Marital Status 1 X Never Married 2 3 Widowed 4	Divorced	Armed 1 Ye If Yes, Give or Dates:	Year] No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:							14. Race - American Indian, Black, White, etc. Specify: White 6b. Kind of Business/Industry			
5-0036 led within 72 hours after dygene. other than "natural", the Medical Examiner	Completed	15. Decedent's Education Elementary/Secondary (College (1-4 or 5+)			durin	ng most	Osual Occupa of working life ntry		Scl			sociate	S		
21215-0036 ould be filed within 7 Mental Hygiene, s marked other than ic event, the Medica	De Con	17. Father's Name (First, N Basil White							18.Mother's Name (First, Middle, Maiden Surname) Gertrude Rich								
MD 21 d 2 should lth and Me n 27 is ma tumatic ev		19a.Informant's Name/Rel Beth Johnson				l	33	5 M	eadowt	rail;		ral Route Number, City or Town, St ca,PA 17314					W
ore tra												Date /2010	We	20c. Location - City or Town, State West Chester, PA			
Baltimo permit. Page Department of Important: injury or ott	Ī	21. Signature of Funeral S		see //	nirect		2	22. Nam	e and Addres	s of Facility	Poor	ing Car	go F	.H. 3.	33 5	Parke	St
		23a. Part I. Enter the dise		1/1 1/1/	11			Bal	timere	Mar	1141	d; 655 d.2120	Abe	rdeer	i, MI	21001 Approximate	Interval
Physician /Medical :aminer		failure. List only one Immedia Cause (Final di	cause on ea	ach line. Atheroso	clerotic Ca	ardiovas				,, such as c	and lac or	respiratory a	irest, si	lock, of fie	art	Between Ons Death	set and
7		or condition resulting in de Sequentially list conditions	b.	`	as a consequ												
		if any, leading to immediat cause. Enter Underlying ((Disease or injury that init)	ated c.		as a consequas a consequ												
uted nd ransit	_ !	events resulting in death)	Last d.		uo u oonoogi	201100 017.											
760, Toate be executed sphysician and the burial - transit	Medical	UNPENDED	X	AMENDE	#9,1	7,20a	a-c,2	22,	per Fl	1 g900	2/2	23/10 7	ГТ				
Box 68760, e death certificate by the attending physic ed for use as the bur	Clan										_	ay Ye	ear				
ires that the dea signed by the a lbe detached for	by Prny	Part II. Other significant of		a [] 0	nknown ng to death b	ut not resi	ulting in t	the und	erlying cause	given in Pa	art I.		_			he cause of dea	
of Vital Records, P.O. Box 68' ag Physician: The law requires that the death certificate has been signed by the attending meral director, page 2 should be detached for use as	Completed											24a. Wa		24b. \	Vere aut	opsy findings a ompletion of car	vailable
Rec The la cate h	팅												2 🗸			s 2 <u> </u>	No
Vital Recysician: The his certificate director, page	8	25. Was case referred to n examiner?	F	Hospital: ₄ ┌	Inpatient	2 E	R/Outpa	tion! ?		Other	<u> </u>	nly one) Home 5	Pasid	lence e l	/ Other	Scene	
C # _ ^ # i	non:	1 Yes 2 N 27. Manner of Death 1 Natural 5	Pending	(M	Date of Injury Ionth, Day, Year	12	28b. Time		ry 28c. Inj	ury at Work	(?	28d. Describe					
by c a A 50	Certification:	2 Accident 3 Suicide 6 4 Homicide	Investigati Could not determine	be 28e. F		y - At hom	ne, farm,	street, f	actory, office	building, et	tc.	28f. Location or Town,		and Numb	er or Rur	al Route Numb	er, City
8 - 2 >	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medic	ing Physic al Examine	ian: To the r:On the ba and mann	sis of examir	nowledge	, death o	occurred	at the time, on the street in	date and pla on, death oc	ace, and occurred at	due to the car the time, dat	use(s) a e and p	ind manner lace, and d	as state	ed. e cause(s)	
To vittle	ME	29b. Signature and title of	certifier	w)					.M.E.				Date sign		th, Day, Year)	
		30. Name and address of Laron Locke MD.		0.0	cause of dea lical Exam			enn S	treet, Balt	imore, M	ID 2120	01					
Sta Registr	~	31. Date filed (Month, Day		010 32	2. Registrar's	Signature		par	Kel								
DHMH 17 Rev 1/2001 OCME ORIGINAL																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep	partment of Health and Mertificate of Death		ene g. No. 0 0	05134
	^		Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medic		Barbara E. Zimmerman		7	21 10	4 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	l
			Edenwald	TOWSON If Under 1 Year If Under 24 Hrs.	9 Data of Birth	Baltimore	In an /State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 T F 93 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Mar. 8,	Year) 9. Birthp Cour	place (State or Foreign htry) Maryland
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		1	0d. Inside City Limits
	Aaryla I sho	ō					1 ☐ Yes 2X No
	288-	Director	MD Baltimore Towson	10f. Zip Code	10	og. Citizen of What Cour	ntry?
	3a or		800 Southerly Road Apt 604	21286	11	JSA	
	death ms 2	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	
9	or ite	교	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Black, White, Specify: Wh	
21215-0036	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-f show The Macical Examiner i ust be motified at	d by	3 Widowed 4 □ Divorced Year or Dates:	TE Tes 25/110 Specify.			
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12	within 72 ene. than "nai he Modic	d L	Elementary/Secondary (0-12) College (1-4or 5+) Teach		1	ducation	
0	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name			
Maryland	o d a	To B	Lawrence E. Ensor	Addie May	Wheeler	•	
ary	should and Men s marke tumatic			ling Address (Street and Number or Rura			Code)
	1 and 2 Health a em 27 is			Stringtown Road;			
ore	0 0		20a. Method of Disposition 1 🖾 Burial Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cr	position (Name of ematory or other place)	Date 2	20c. Location - City or To	own, State
Ē	Pages ment of I tant: if it		'4 □Donation 5 □Other (Specify) Clynmal1	ra UMC cem. 2/25/	10 P	hoenix, MD	
Baltimore,	permit. Pag Department Important: i any injury o		1611111	22. Name and Address of Facility			ork Road
	40580		23a. Part1. Ehter the disease, or complications that caused the death. Do not el	ick Towson Funeral			, MD 21204 Approximate
	Physician		shock, or heart failure. List only one fluse on each line. Immediate Cause (Final disease or condition	rge lung	dine		Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence	1 - 1 +	1 2.		Fine
		-	Sequentially list conditions, frank, leading to immediate b. Due to (or as a consequence of).	en sily in	ance	use	071
	uted t insit	Examiner	cause. Enter Underlying Cause (Disease or injury				1120
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9	ng ph as th		IF FEMALE:				
Вох	death certific attending pl	lan/Me	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy		23d. Date of delive Month	ery Day Year
o.	the all	ysici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			<i>5</i> 4,
٥.	that the di ed by the detached	Physi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	he cause of death?
rds,	es De	ed by	<u> </u>		1 ☐ Yes	s 2 No 3 Prot	bably 4 Unknown
Vital Record	a ×	Completed			24a. Was an	24b. Were auto	psy findings available mpletion of cause of
Ä	9 4 9	mo.			perform	ned? death?	2 No
'ita	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one	9)	
of \	Q Q	ို	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			nce 6 Other (Specif	ý)
	After unerg	ion:	27. Mann Death 28a, Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how	w injury occurred	
isic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location (Str	reet and Number or Rura	al Route Number
Division	I or Attendation after death Director:	Certification:	4 Homicide determined building, etc. (Specify)	treet, factory, office	City or Town,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Qertifying Physician: To the best of my knowledge, deal (Check only one) Amedical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as s ite and place, and due to	stated. the cause(s)
	within 2 To the 2 complet	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Jay, Year)
}			I / (Man mh sì u	in D297	69	2/22/	10
	8		30. Name and address of person who completed cause of death (Item 23a) (Type	5/h MRol	in Rd	Buffo 0	id 2128
	, Sta Registr	- 31	31. Date filed (Month, Day, Year) FEB 23 2010 22. Registrar's Signature	all of	7,4		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 330 M -9119 12 n 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center lestminster Itespill 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In-yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Hours 63 Director 1946 Texas 465-84-0213 Sept 6, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 ☐ Yes 2 No Director Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or USA 32 Bella-Vita Ct. Unit 1C 21157 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 🏖 No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced White Be Completed th and Mental Hygiene. 7 Is marked other than "natur traumatic event, Ire Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe M. Maceiras ဂ္ Laura Mae Bouvier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benny C. Allen Husband 32 Bella-Vita Ct. Unit 1C Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o one. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc Catonsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner W へいつしょ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of a ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

ever a first of this certificate has been signed by the attending physician and filled in by the funeard director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>S</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No 24a, Was an 1 XYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier WJL 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grangervio Memorial Ave Westminster MD 21157 200 MrILO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 2 Cay 2:47 PM NORMAN BLAKE 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MARY'S HOSPITAL EON ARD TOWN ST. MARY 5. Social Security Number 220-40-4939 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Pay, 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign (Month, Day, Year) Washington, DC 66 10111 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 K Yes 2 No Montgomery Gaithersburg Maryland 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 18800 Walkers Choice Road 20879 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4x Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Appliances Service Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Blake** Nadine Stringham Sidney Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14911 Plainfield Ln., Darnestown, MD 20874 Roberta Blake Solis/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Mt. Zion Cemetery 02/03/2010 | Bethesda, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. . Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE HEPATIC disease or condition resulting in death) Due to (or as a consequence of): YEARS CIRR ATIC Sequentially list conditions it any, reading to immediate cause. Enter Underlying Cause (Disease or injury YEARS O HOL that initiated events Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STAGE IZENA 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performe Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No 26. Place of Death (Check only one) Other: 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 \(\sum \) Yes 2 \(\sum \) No 5 Pending 2 Accident 3 Suicide Investigation

ospital or Attending Physician: The law requires that the death certificate be executed I hours after death.

Unoursal Director: After this certificate has been signed by the attending physician and additionable to the burnar director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be nieu wissing. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur Important: If item 27 is marked other than "natur Important: If item 27 is marked other than "natur Important."

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Physician/Medical

Completed by Be ျ Certificate: Medical

To the H	within 24 To the F complete
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Louis KRIGER State Registrar

4 Homicide

29a. Certifier

(Check

29b. Signature and title of certification

6 Could not be

determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D 50350 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

25500 POINT LOOKOUT ROLLEONARD TOWN, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Porvar 0 Nancy Lee Bennett Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Oct. 8 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland **Funeral** If Under 24 Hrs. 1 □ M 2 😾 F Months Days Hours Min. **Director** Yrs 215-68-6937 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🏋 No Maryland Washington Clear Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14837 Mercersburg Road 21722 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. White 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 0 Inspector Tannery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>John Stevens</u> Mary Nicodemus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Bennett - Husband 14837 Mercersburg Road, Clear Spring, MD. 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 2/11/10 Williamsport, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, MD. tred 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acure Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Pregnant at time of death 5 Other (specify) Day Year ed by the a 1 ∐ Yes 2 L 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tobsillana 1 Yes 2 No 3 Probably 4 Unknown need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed' 1311 @ Here MPJ M OUT 1 ☐ Yes 2 ☐ No 1 Yes 2 4No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 14 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner - eath 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) -Natural injury 5 Pendina 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined nin 24 hours a the Funeral D pleted filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2 State

only one)

29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONIEU

egistrar's Signature

Registrar

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 00611

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore, Maryland 21215-0036	d 2 shoul alth and n 27 is m er traums		19a. Informant's Name/Relationship (7) Raymond D. Bourd		and P	Mailing Ad	dress <i>(Street ar</i> 30x 185	nd Number or Rura , Lonacot	ning, M	er, City or Town, 1 D 2153	State, Zip (Code)		
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89	eath certifice attending p	N W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy					23d. Da	ate of delive	erv		
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours. (Far death. To the Funeral Unrector. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Completed by Pi	Part II. Other significant conditions of		,	the under	ying cause give	en in Part 1.				ne cause of death?	'n	
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<u>e</u>	hysician: The lar nis certificate ha I director, page 2		25. Was case referred to medical examiner?				26. Pla	ce of Death (Check		Z EJ NO	1 🗆 163	2 2 140		
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	To the Hospital r Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2 ☐ Medical Exami only one) 3 ☐ Certifying Nurs	sician: To the best of mer: On the basis of exa e Practionar To the basis	mination and/or	investigation	on, in my opinior	n, death occurred at	the time, date	and place, and du	e to the ca	use(s) and manner star	ted.	
	C C C C C C C C C C C C C C C C C C C		29b. Signature and title of certifier	nAlla	note.		29c. License D00	number 154004		29d. Date signe	d (Month,	20/0.		
•	فس		30. Name and address of person who could be supported by the Shiv C. Khani	completed cause of dea			onal Hi	ghway, L	aVale,	MD 215	02			
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend #25, 27 & 28a-1, perME, g901 3/26/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Month Physician/ 5:30 29 а Berenice Lillian Brown January Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Rockville Nursing HOme 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min. 01/01/71913 1 M 2 XF Hours 97 PA Director 199-09-4996 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at onee. 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No VRD Rockville MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20853 5036 Baffin Bay Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Force þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Social Worker 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Yetta Kabatchnick Jacob Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5036 Baffin Bay Lane, Rockville, Maryland 20853 Deborah Ann Brodey, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Temple Israel Cemet. 02/01/2010 Dunmore, PA 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION,
1091 Rockville Pike, Rockville, 21. Sign xure Fun and Service Licensee 20852 MO1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hemorthage Physician. Intraverial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying EDICAL EXAMINER Examine Due to (or as a consequence of) GERTIFICATION APPROVED BY Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and de detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown g
Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 🗌 Yes Records, Be Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 2 🖳 No After this certificate Yes 2 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific to propleted filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury subject fell off toilet T Natural 5 Pending 2 No 1 Yes 9:00 a 01/13/2010 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number of Rural Route Number City or Town, State) 18100 Cashell Rd Rockville, MD 28e. Place of Injury - At home, farm, street, factory, office Assisted Specific Ving 3 ☐ Suicide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3 D0064624 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gathersburg Walk Dr. 743 SANDEEP SHARMA Summer 31. Date filed (Me

Registrar DHMH 17 Rev 7/2009

State

Registrar's Signature

			For AMEND#19A per FH 1 - Registrar 2/16/10 AACO H	State of Mar	-	epartme <i>Certifica</i>			nd Me		giene Reg. No	0010	1 0 5	5 1
			Decedent's Name (First, Middle, Last						2.	Date of Dea	ath	<u> </u>	3. Time	of Death
	Physici	an				13	2 4			Month (1 /	3 C	y Year	1415	d M
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Death						County of Death		1 0
3	Examir	er	4a. Pacifity Name (if not institution, give	street and number)		12	/ /	LOCATION OF L	-					
			5. Social Security Number 6. Se	y 7 Age	(In yrs. last birth	nday) If Und	er 1 Year	If Under 24	Hrs. 8	Date of Birt		None 9. Birth	nplace (State	or Foreign
	Funeral		1[7 to 0.00 F		rs. Months	Days	Hours 1	L	Date of Bird (Month, Da			untry)	
	Director		219-12-3281 Usual Residence of Decedent		/				At	<u>ıg. 8</u>	19	ZZ Mary	yland	
	and and		10a. State 10b. County	1	0c. City, Town	or Location						-	10d. Inside	City Limits
	f sho	ō				_							1 <u></u> ₹ Ye	s 2 No
	he A	Director	Maryland Anne 1 10e. Street and Number	Arundel	Arno1		ip Code				10a Cit	tizen of What Co	untry?	
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	be filed within 72 hours after death with the Maryland tial Hyglene. 4d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at	Funeral				40 Was Das			0 /0000	· · Va a ar Na		14 Page Ame		
	tem term	un	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	If Yes, sp	ecify Cuba	ispanic Origin ın, Mexican, P	uerto Ric	y resorno an, etc.)	-	 Race - American Black, White 		
36	or i	by F	1 Never Married 2 Married	1 ∐ Yes ≱ No If Yes, Give		1 □ Yes	2 K No	Specify:				Specify: B	lack	
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nd	should be filed withir nd Mental Hygiene. marked other than matic event, tre M	Be	17. Father's Name (First, Middle, Last)					18. Mother's				i Surname)		
<u>la</u>	Men Men arke	ဥ	Jesse W. Pa	arker				Fran	ces	John	son			
Maryland	s 1 and 2 should be fi f Health and Mental H item 27 Is marked of other traumatic eve		19a. Informant's Name/Relationship (7	ype. Print)	19b.	Mailing Addre	ss (Street a	and Number o	or Rural F	Route Numb	er, City	or Town, State, 2	Zip Code)	
	5 # 2 F		Linda Ray Roy	(Daughter) 2	2463 S	ymph	ony L	a. 0	ambr	i11	s, Md.	2105	4
ē			20a. Method of Disposition		20b. Place of cemetery	Disposition (N	ame of	ee)	Date	9	20c. L	ocation - City or	ocation - City or Town, State	
E	Pages nent of int: If its		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Adams				/8/1	.0	Lot	hian, N	Md.	
altimore,	그 든 말 금		21. Signature of Funeral Service Licens						· ·			, P.A.		
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	_		23a. Part 1. Enter the disease, or comp									0. 214	Approxim	ate
			shock, or heart failure. List only of	one cause on each line		,							Interval B Onset and	
and the	Physician /Medical		disease or condition resulting in death)	4.	achno	1d	_h.	emor	rho	298			230	a45
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		<u>_</u>	Sequentially list conditions,	b. Ceve	Soul	an	en	450	7					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	1).		L						
	ecut and tran	хап	that initiated events resulting in death) Last	cDue to (or as a	consequence o	f).								
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8760,	ficate be executed physician and s the burial-transit	dical		d										
9	eath certific attending p for use as	Mec	IF FEMALE:											
Вох	tend r use	an/	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		3 🗆 Ectopia	pregnanc	y				23d. Date of del Month	ivery Day	Year
	dea ne at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death	5 Other	(specify) _	-				MOTH	Day	I C di
P.0	at the de by the tached	Physician/Me	9 🗆 Unknown											
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by F	Part II. Other significant conditions co	ontributing to death but	not resulting in	the underlying	cause give	en in Part I.		23e. Did t	tobacco	use contribute to		-
Records,	quire en siç uld b	ğ								1 🗆	Yes 2	! □ No 3 □ Pr	robably 4	Unknown
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Be	The law cate has page 2 s	шć				-					rmed?	death?	completion of	cause of
a			05 W						15 11 1	1 □ Yes	2 111	o 1∐Yes	2 □No	
Vital	sicial certi recto	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place o						
of	Physician: r this certific rai director, p	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☑ Inpatien 28a. Date of Injury	t 2 🗆 ER/Out	·	28c. Injur	4 ⊔ Nurs		d. Describe		6 ☐ Other (Spe	cify)	
L	ng ffe	io	1 ☑ Natural 5 ☐ Pending	(Month, Day,	Year) Ir	njury M	Worl	k? Yes 2 □ No		u. Describe	now inju	ny occurred		
Sic	Attendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be		At home for			res Z LINC		Location /	Ctroot o	nd Number or Ri	ural Boute No	umher
Division	or A fifter (Direct in by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	III, Street, lact	ory, office		20	City or To			arar rioute ret	mibei,
	urs a urs a eral [00- 0-455-x 417/0-455-n- Ph	uninters To the book of		d			-1			a) and manner a	o etatod	
	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer	ical		ysiclan: To the best of hiner: On the basis of	examination and									e(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature and title of certification	and manner state	su.		9c. Licens	e number			294 D	ate signed (Mont	h. Dav. Year)
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6	113		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, Print)				, .		1-30-		
$\overline{}$	11/		than Po	ritka	22 8	Great	ene	50	Da	Hin	101	(P. M.	0 3	1201
	Sta		31. Date filed (Month, Pay, Year)	32. Pegistrar	's Signature	hove	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed burial-trar physician for use as the þ signed by , page 2 should funeral director, this After t or Attending death. 24 hours after death Puneral Director; filled in by Hospital

completely within 24 5H2+1

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington County Cynthia Kuthor Sands mo Hospice of Washington Hagersto Kuttner

2010

thea Kuttrey-Sands, no

and manner stated.

DHMH 17 Rev 1/2001

1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D47451

29d. Date signed (Month, Day, Year)

Hagerstein Maryland 21742

February S, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 8:05 Ρ. Lozupone Carney Gloria anuary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days July 10 1 □ M 2 🛣 F Hours Mary Land Director 577-32-4918 82 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2X No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 16501 Henry Drive 20877 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces þ 1 Never Married 2 K Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Small Business Owner Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stephano Lozupone Colacicco Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Turley Drive, North Potomac, Maryland 20878 William S. Carney/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2/1/2010 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Arrythmia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as the k IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 🔀 No detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? this certificate 1 Yes 2 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 🗌 Yes 2 X No Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 5 Pending 1 🛣 Natural work? 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director, A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one) 29b. Signature and title of certifier

Brian Carpenter, M.D.

FEB 02

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

DHMH 17 Rev 7/2009

29c. License number

D 64502

9901 Medical Center Drive, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

February 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra AMEND#23aI+IIpenMD, 2/12/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\stackrel{\mathsf{Month}}{\mathsf{JAN}}$. FRANCES ODELLE CANDLER 2010 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SANCUARY AT HOLY CROSS BURTONSVILLE If Under 1 Year 8. Date of Birth (Month, Day, Year) FEB 6, 1911 Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours Days VIRGINIA Director Yrs. 223-12-9999 98 Usual Residence of Decedent 28a-f shov 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ıral", or items 23a or 28a-f s I Examiner must be notified 1 🏋 Yes 2 □ No MD MONTGOMERY SILVER SPRING 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 NORTHWEST DR. 20901 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 □ Widowed 4 □ Divorced Specify: WHITE the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ TEACHER PUBLIC SCHOOLS of the and Mental Hygier 27 is marked other to traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke JOHN HUDSON JANIE GARRETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. DAVID CANDLER/SON 415 OAK SQUARE, SAN ANTONIO, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) PARKLAWN CEMETERY 2-5-2010 ROCKVILLE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL 5801 CLEVELAND A HOME & M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart Failure Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Advanced Dementia peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' After this certificate 2 No 1 Tyes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 2 100 Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) è -29-10 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

mith

31. Date filed (Month, Day, Year) FEB 0 2

avenue

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 **Physician** Richard L. Cape, Sr. 2, 7:09p M Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1**½** M 2□ F 8/15/1942 PA. 67 215-42-8234 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 27 No Carroll Hampstead Director MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21074 4401 Upper Beckleysville Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 □Yes 2 No Specify: If Yes, Give Year or Dates: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farming 11 farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Malcolm W. Cape D. Luetta Reed ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Romaine Cape, wife 4401 Upper Beckleysville Rd., Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead Cemetery 2/8/2010 4 Donation 5 Dother (Specify) Hampstead, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home Thanda or demmer 934 S. Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AORTIC ANEURYSM **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY DISEASE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ERI PHERAL Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 2 ☑No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🛂 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

law requires that the death certificate be executed Box 68760 Ö σ. Records, of Vital Division

and-trar attending physician a for use as the burial-t signed by the cate has page 2 s certificate Hospital or Attending Physician: this certifical To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the ft death.

Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hyglene.
Int: If item 27 is marked other than "natural", or items 23a or:

Baltimore, Maryland 21215-0036

NJL State

29b. Signature and title of cartifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D0069124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

WESTMINSTER MD 21157 STONER AVE

31. Date filed (Month, Day, Year) FEB 05

KRISTIAN

29a. Certifier

(Check only one)

Medical

HOCH BERG, MD 32. Registrar's Signature

Registrar

193

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. , 20b per HNS late of Maryland / Department of Health and Mental Hygiene 2 [] | [] = State 2/5/2010 AACO HEALIH DEPT. CMH Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2/1/2^{Day} Physician/ 11:15am™ Henry Contee Bowie Clagett Jr. Medical 4a. Facility Name (if not institution, give street and number)
Anne Arundel Mecleal Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Social Security Number er 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Hours **X**X M 2 □ F 1172271916 DC 93 **Director** 215-38-6072 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Anne Arundel Davidsonville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21035 3856 Wayson Rd. USA 12. Was Decedent Ever in U.S.
Armed Forces?
XX Yes 2 □ No 1938If Yes, Give 1045 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced 1945 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law Firm/ Partner Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Katherine Marbury Henry C. B. Clagett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6601 Old Crain Hwy Upper Marlboro, MD 20772 Henry Clagett III Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2/2°4°2010 permit, Page 1
Department of I
Important: If its
any injury or o cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/2/2010 Glen Burnie, MD . Signature of Funeral Service Lightse 22. Name and Address of FacilityHardesty Funeral Home, P.A. 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph si ian neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L g Unknown been signed by the should be detached q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 N this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: Certificate: To 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier mid D69566 2/1/10 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21401 Michel polis IVELISSE Medica 7,001

Registrar

31. Date filed (Month, Day, Year)

FEB 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death OF 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 2010 Frances Shirley Dabrowski 7:55 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8908 N. Westland Drive Gaithersburg Montgomery 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days (Month, Day, Hours Min 4.1927 161-22-6615 Months 82 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 8908 N. Westland Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗓 No Black White etc 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Shirley Maude Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mirek Dabrowski - Spouse 8908 N. Westland Drive, Gaithersburg, MD 20877 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Crematory 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral HOme 10 East Deer Park Drive, Galthersburg, MD 20877 RACI MULA 10111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2 Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Diffuse Large B - Cell Lymphoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter enderlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy perform Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \sum Yes

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician for use as the burial

Physician/

Medical

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Mental Hygiene. larked other than

permit. Page 1 and 2 should Department of Health and Mi Important: If item 27 is man any injury or other traumati

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

signed by t page 2 should has After this certificate

Division of Vital Records, P.O. Box 68760

Physician/Medical by Completed Be မ

Certificate:

Medical

27. Manner of Death

1 X Natural

4 Homicide

Accident Suicide

2**X** No

31. Date filed (Month Day, Year) FEB 0 5 2010

5 Pending

Investigation 6 Could not be

determined

Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

29b. Signature and title of certifie q. Westerman. 29c. License number D52451 29d. Date signed (Month, Day, Year) February 3, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael A. Westerman, M.D., National Naval Medical Center, Bethesda, MD 20889

State Registrar 32 Registrar's Signatur Darke

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			For State Registrar		State of Ma	iryiand /	-	rtment of H tificate of E		Mental I	Hygiei Reg.i		3 0511 =
	Disconing		1. Decedent's Name (Firs	t, Middle, Las	t)					2. Date of	f Death	Day Year	3. Time of Death
	Physicia /Medic		Vincent A. D	iggs								30, 2010	12:18 PM ^M
	Examin	er	4a. Facility Name (If not in	_				4b. City, Town, or		h		4c. County of Death	n
900			Frostburg Villa 5. Social Security Number				(mathematics)	If Under 1 Year	Frostburg	O Date o	Divth	Allegany	enlace (Ctata or Comiss
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	and		Usual Residence of Deceded 10a. State 10b.	County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	Maryl f sho	호	Maryland	Allega	nv	Frostb	1110						1 □ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number		oodland Road		B	10f. Zip Code			10g.	Citizen of What Co	untry?
	h with	a D		19904 W	Oodiand Road	L, D. W.		21532-			U.	.S.A.	
.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercitive roughts nothing a some.	Funeral	11. Marital Status 1 Never Married 2	Married	12. Was Decedent E Armed Forces? 1 ★Yes 2 □ No		13. W	/as Decedent of His Yes, specify Cubar	spanic Origin? (n, Mexican, Puer	Specify Yes o to Rican, etc.	r No-)	14. Race - Amei Black, White	
036	urs a al', o	ğ	3 ☐ Widowed 4 ☐ D	,	1 Mayes 2 □ No If Yes, Give Year or Dates: \	NWI	1	□Yes 2 No	Specify:			Specify: Wh	nite
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and	d be fi	Be	Vincent Amb		ne				Clara Re			ien sumame,	
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Baltimore, Maryland 21215-0036	permit. Departmitimporta Importa any Inju		21. Signature of Funeral S	Service Licen	see	,,	-	Name and Addres		,,			,
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	2+		39. Name and address of 31. Date filed (Month, Day	person who o	completed cause of de	ath (Item 23a)	(Type, P	rint)		2 ,		,	,
	MRS		MARINTS	idhui	MD. 935	Bish	op	WAST A	ed. C	umbe	RIA	nd, m	21502
	Sta	te	31. Date filed (Month, Day	, Year)	32. Registra	r's Signatur	Mark	1				,	
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security N 085–22–24		6. Sex	M 2 🖰 F		In yrs. la 88	ast birthday) Yrs.	If Unc Month	ler 1 Year s Days	If Under 24 Hours	Hrs. Min.	8. Date of Bi	irth lay, 192	21		nplace (State or Foreign http:// York	7
and show dat	tor	Usual Residence of 10a. State	Decedent 10b. County				10c. City	y, Town or Lo	cation	-							10d. Inside City Limits	;
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	≦	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		ried	. Was Deced Armed For 1 Yes If Yes, Give Year or Da	ces? 2 🔀 No					ispanic Origir in, Mexican, I Specify:	n? (Spe Puerto	ecify Yes or No Rican, etc.))-	Riac	e - Ameri k, White, Whit e	ican Indian, , etc. 2	
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Page 1 a ment of H tant: If ite lury or oth		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	X Cremation		moval from	State	C	Place of Dispo emetery, crer cropolit	natory or	other plac		Jan.	Date 28, 2010	l			^T own, State V irginia	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Yo the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 2 9 ☐ Unknown	months?	23c	. If yes, outo 1 Live E 4 Pregn 9 Unkno	Birth 2 ant at ti	☐ Feta	Ideath 3	Ectopio	c pregnanc specify)	У				23d. Dai	te of deliv	/ery Day Y ear	
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 seconds.	al Certi	4 Homicide	6 ∐ Could determ			of Injury g, etc. (me, farm, stro	et, facto	ory, office			28f. Location (City or To			er or Rura	l Route Number,	
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	ŀ	30. Name and addre	ess of person shurst, I	who comp	oleted cause 3110 G	of deat	th (Item	23a) (Type, F	rint) Silve	er Spri	ing, MD	209	04					
State Registra	e r	31. Date filed (Monti), Day, Year) 0 2 2	010	32. Re	gistrar's	Signati	ure fact	10				_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:58 p_M Jantary Elizabeth Donahue 27, 2019 Marv Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kensington Montgomery Kensington Park Retirement Communit Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Hours Dec 4, Year 929 80 Pennsylvania 577-38-7699 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Kensington Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20895 USA 3636 Littledale Road 72 hours after death with 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐**X**No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: White 3 k Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James I. Nolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VA 22302 1503 Kenwood Avenue, Alexandria, Frederick M. Donahue/Son 20a, Method of Disposition 20b. Place of Disposition (Name of Feb. 22 2010 20c. Location - City or Town, State Arlington National 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Arlington, Virginia 4 Donation 5 Other (Specify) Cemetery Signature of Funeral Service Licensee Francis Address of Collins Funeral Home Inc Spring, MD 20901 500 University Blvd. W., Huss Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Acute Coronary Syndrome Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate

Enter Underlying

Cause (Disease or iinjury Exami the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for or Attending Physician: The law requires that the death in the past 12 months? Month Year Day Pregnant at time of death Yes 2 X No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe 1 Yes 2 No 3 Probably 4 No Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 XYes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work? 1 Tes 2 No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Jan. 27, 2010 D67355

State

Registrar

parke

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Daniel K. Sherk, MD

EB () 2

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Buisson 6:50 am Jean Desir 2010 anuanu Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 610 Chichester Lane Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days Min 08/2074920 Director 157-96-1073 89 Haiti Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Manyland all Hygleine.

J other than "natural", or items 23a or 28a-f sho dother than "natural", or items 23a or 28a-f sho want, the Medical Examiner musts be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Silver Sprina Montgomery 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 610 Chichester Lane 20904 Haiti 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married Yes 2 No þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer nit. Page 1 and 2 should be filed witl artment of Health and Mental Hygien ortant: If item 27 is marked other I injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Homer Desir Ephrosia Cheristil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chantal Nicolas - Daughter 610 Chichester Lane, Silver Spring, Maryland 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 02/06/2010 | Silver Spring. MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysician Heart Attack disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events southing in death) Leat. Due to (or as a consequence of Exami <u>Ath</u>erosclerosis and -tran Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical that the death certificate be Box 68760 as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months? Month Year Pregnant at time of death 2 \square No the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by of Vital Records, Hospital or Attending Physician: The law requires Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been signal Completed Were autopsy findings available prior to completion of cause of Metastatic Prostate Cancer 24a. Was an autopsy death? nerforme certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{XI Residence} \) 6 \(\text{Other (Specify)} \) ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral (Month, Day, Year) 1 X Natural 5 Pending work? Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 현 29c. License number 29d. Date signed (Month, Day, Year) 29 2013 123937 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.,

Registrar DHMH 17 Rev 7/2009

State

Rashid Baghai Naini.

31. Date filed (Month, Day, Year) FEB 02

2. Registrar's Signature

344 University Blvd., W., Ste 324, Silver Spring, MD20901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Registrar AMEND#1perMD, 2/5/10, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Catherine R. Ehrman 2. Date of Death 3. Time of Death Physician/ Month 2°3 2010 Catherine R. Erhman 8:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MAnor Care of Chevy Chase Chevy Chase Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours 2M7th P3 32" Michigan 566-36-4942 77 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No DC Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 1731 Crestwood Drive, NW United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Officer Federal Government of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry JAmes Louise Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 15357 15Mile Road, Marshall, Michigan 49068 S. James/ son Michael 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) Chesapeake Crematory 1/29/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Signature of Funeral Service Licenses 20012 7400 Georgia Avenue, NW, Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Breast Cancer Physician/ disease or condition Medical resulting in death) **Examiner** Metastasis of cancer to brain, lung & esophagus Sequentially list conditions, Due to for as a consequence of) if any, leading to minediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year 4 ☐ Pregnant at time of death g ☐ Unknown the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 H Unknown 24b. Were autopsy findings available prior to completion of cause of death? Generalized deconditioning 24a. Was an has le 2 s autopsy performed Yes 2 page certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🛛 No Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 IDOA After this s after death.

I Director: After this d in by the funeral d 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work 1 Tyes 2 🗌 No Accident Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo Completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

7710 Bradley Blvd., Bethesda, MD

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kirti Vohra, MD
31. Date filed (Month, Day, Year)

FEB U5

MD D - 20274

20817

1/25/2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Edelson Max 4:25 A. M January 26 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville 1801 East Jefferson Street 8. Date of Birth (Month, Day, Aug. 13 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Hours Min 1 X M 2 - F 136-01-9107 Director 95 1914 New_York Aug Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland must be notified at Director Rockville Montgomery MD 1 X Yes 2 No 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20852 Unites States 1801 East Jefferson Street items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 6 þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 X Widowed 4 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Development Real Estate 4 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Edelson Cecelia Edelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard N. Edelson/Son 7426 Hampden Lane, Bethesda, MD 20814 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Geo. Washington, D.C. Washington, D.C. 1 Burial 2 Cremation 3 Removal from State injury or 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licenses 9013 Annapolis Road, Lanham, MD 20706 M00969 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Caronan disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrilla Sequentially list conditions Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this n 24 hours after death.

Per Funeral Director: After the poleted filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 211/2010 0064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20 852 1 801 Fazh,

State

Registrar

31. Date filed (Month, Day, Year)

FEB 02 2010

3. Registrar's Signature

		-	For State Registrar	State of Ma	-	epartm Certifica						A = 1 P 1		
			Decedent's Name (First, Middle, Las	t)		00/11/70	<u> </u>	Cutif	2. Date of Dea) 0	3. Time of Death		
	Physicia Medic			Finley					January	31, 20	10 Year	2:15 a.m.		
	Examin	er	4a. Facility Name (if not institution, give			j		Location of Death		4c. Count				
- 1	Funeral		St. Mary's Nursi 5. Social Security Number 6. S		In yrs. last birth			If Under 24 Hrs.	8. Date of Birt	St. M	9. Birthr	place (State or Foreign		
	Director		311-16-5011 1 Usual Residence of Decedent	□м 2 🛛 F	91	rs. Mont	hs Days	Hours Min.	09/11/1	y, Year) 918	India	ina		
	aryland la-f shov ified at	Funeral Director	10a. State 10b. County Maryland St. Mary		10c. City, Town Leonard						1	l0d. Inside City Limits 1 🌠 Yes 2 □ No		
	the M or 28	١	10e. Street and Number	5 1	Leonard		. Zip Code			10g. Citizen of	What Cour	ntry?		
	s 23a nust b	hera	22680 Cedar Lane	Court, Apt.	1324	2	0650			United	State	S		
920	be filed within 72 hours after death with the Maryland ential tygiene. Ked other than "natural", or items 23a or 28a-f show tie event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	er in U.S. o	If Yes, s	ecedent of His specify Cubar es 2 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, e	etc.		
2-0	natur dical	plete	15. Decedent's E (Specify only highest gra	ducation	16a.	Decedent's L	Jsual Occupa	ition uring most of work	ring	16b. Kind of E				
21215-0036	e filed within 72 hour tal Hygiene. ed other than "natu event, the Medical		Elementary/Seconday (0-12)	College (1-4 or 5+)		iife. DO NOT acher'	use retired)		arig	Educat	ion			
pu	filed wit al Hygie d other event, th	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle,	Maiden Surnam	e)			
Уa	uld be fill Mental narked o	မ	Charles Otis Benn					Jennie M	iay Benn	ett				
Maryland	2 shouth and the and the and traum	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Michael Finley/Son 29873 Hillary Avenue, Easton, MD 21												
o	The second secon											own, State		
Baltimore,	1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) Northern Indiana Cre 02/05/2010 Ft. Way											ndiana		
Balt	permit. Depart Import any inj	20c. Location - cemetry, crematory or other place) 1												
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between		
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	ficate g physas the			d										
. Box 68	to death certificate be executed the attending physician and ched for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3		/			ate of delive onth	ery Day Year		
s, P.O.	s tha gnec se de	à	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlyi	ing cause give	en in Part I.				ne cause of death?		
ord	law require has been si je 2 should b	Completed							24a. Was autor		Were autor	psy findings available mpletion of cause of		
Rec	The Is cate hs page	Com								rmed?	death? 1 Yes			
ital	sician: certifik rector,	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othe	ce of Death (Chec						
of V	y Physer this eral dii	e: <u>1</u> 0	27. Manner of Death	28a. Date of injury	t 2 ER/Out	me of	28c. Injury	4 LX Nursing He	ome 5 Resid)		
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	e Hospital 24 hours a e Funeral l	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner so a stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
_	To the within 2 To the comple	_	29b. Signature and title of certifier	alr			29c. License			29d. Date signe				
			30. Name and address of person who	ompleted cause of dea	th (Item 23a) (T	ype, Print)			, P	* 1 1-				
			Avani D. Shah, M 31. Date filed (Month, Day, Year)	D. 22650	Cedar]	Lane C	ourt.	Leonardt	own, MD	20650				
	Stat Registra		FEB 0 4	32. Registrar's	Signature A.	par	Ked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 5 2010 Margaret M. Franklin 11:30an February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery 19100 Annapolis Way Montgomery Village Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 05 1 🗆 M 2 🖾 F Months Hours Min. South Dakota 104 June Director 474-10-7865 Usual Residence of Decedent or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 19100 Annapolis Way 20886 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 15 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maria Zenz Martin Langan and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shent of Health stant: If item 27 i 19100 Annapolis Way, Montgomery Village, MD 20886 Dorothy M. Notto (Daughter) If item 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 5 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department or Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 2/20/2010 Mendota Heights, MN 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Days Immediate Cause (Final Physician/ disease or condition resulting in death) Dehydration Medical Due to (or as a consequence of): Examiner Weeks Voluntary Starvation Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 9 Unknown signed by ti Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 ☐ Yes 2 ☐ No ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director; After this certificate filled in by the 2

> State Registrar

Medical

29a. Certifier

only one)

3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29b. Signature and title of certifie

Ε.

DHMH 17 Rev 7/2009

12

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D14555

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Winchell 19241 Montgomery Village Ave., Suite ElO, Montgomery Village, MD

29d. Date signed (Month, Day, Year)

February 5, 2010

	Division of Vital Records, P.O. Box 68760,
	To the Hospital or Attending Physician: The law requires that the death certificate be exect
al	within 24 hours after death.

		Please Type or State of					Ensure Allealth and N	-	_	
	-	For State Registrar		-	Certificate			, ,	leg. No. 2	05156
Dhusisis		1. Decedent's Name (First, Middle, Last)						Date of Dea Month		3. Time of Death
Physicia /Medic	al	David Henry Gai						January	28, 201	
Examin	er	4a. Facility Name (If not institution, give street and no 7050 Carrico Mill Road					Location of Death		4c. County of Dea	_
Funevel		5. Social Security Number 6. Sex		In yrs. last birthd		_	If Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign
Funeral Director		520-30-8261 1 X M 2 F		77 Yrs	Months	Days	Hours Min.	May 28,	1932 Was	hington, DC
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or 28	Director	10e. Street and Number			10f. Zip				10g. Citizen of What C	-
s 23a	Funeral	7050 Carrico Mill Rd.	and and Eve		40 M/ D		0637	!f-:\/No	United S	
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filed v Hygie ther i		1 Z 17. Father's Name (First, Middle, Last)		POL	ice Off	ice		e (First, Middle,	U.S. Park Maiden Surname)	Police
d be ental ked o	To Be	Clyde A. Gainer					Margare	t E. Sc	haeffer	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Examinative Insust by Incitited at once.	-	19a. Informant's Name/Relationship (Type. Print)		I	-				er, City or Town, State,	
and 2 ealth n 27 i	-	Hilda Gainer/Wife							sville, MD	
ges 1 It of H If iter or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from	n State		crematory or o	ther plac	e) Feh	ruary	20c. Location - City of	
it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify)		Marylan	d Vete1		Cem.	2010	Cheletenh	am, MD
permi Depa Impo any Ir		21. Signature of Funeral Service Dicensee		100817			Bri		-Echols F.	H., P.A.,
		23a. Part 1. Inter the disease, or complications that	caused th		PO Box enter the mod	128 e of dyin	, Charlot ng, such as cardiac	te Hall or respiratory ar	, MD 20622 rest,	Approximate Interval Between
Physician		shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	in	Cen	~	20			Onset and Death
/Medical		disease or condition resulting in death) a	o (or as a c	consequence of):						
Examiner		Sequentially list conditions.								
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a c	consequence of):						
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ne dea the a	Physician/Medical	1 Yes 2 No 9 Unknown 4 Pre		me of death	5 Other (sp	ecify)			l literatur	Day Tou.
that the	h h	Part II. Other significant conditions contributing to	death but r	not resulting in th	ne underlying c	ause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
quires n sign ald be	d by							1 🗆 Y	′es 2 □ No 3 □ F	Probably 4 Unknown
aw rec	olete							24a. Was	an 24b. Were a	autopsy findings available completion of cause of
The kate has	Completed							autop perfor	rmed? death?	s 2 No
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Physic this c	2	1 Yes 2X No Hospital: 1 □		2 ER/Outp			4 Li Nuising H		dence 6 Other (Sp	ecify)
ding P. After funer	ion:	↑ Natural 5 Pending (Mo	e of Injury onth, Day, Y	/ea <i>r)</i> 28b. Tin		8c. Injur. Worl 1 □	yat k? Yes 2 □ No	28d. Describe h	now injury occurred	
Attender deatlector:	ficat	a The item of Could not be	e of Injury	- At home, farm (Specify)			103 2 2 110	28f. Location (S	Street and Number or F	Rural Route Number,
talor, safter al Dire	Certification:	4 Homicide determined buil	ding, etc. ((Specify)				City or Tow	vn, State)	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) Certifying Physician: To the properties of the prop		xamination and/						
To the within To the compl	Me	29b. Signature and title of certifier			290	. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
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BA		30. Name and address of person who completed ca	use of dea	2 10	- P(0)	-	M	5 C	0646	
Sta Registra		31. Date filed (Month, Day, Year) 32.		s Signature	barks	,				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month William 2010 Nelson Garner 3:40 January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary' Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/07/1923 1 XM 2 □ F Days Hours **Director** 220-16-5001 86 Usual Residence of Decedent or 28a-f show 10b. County 10a. State hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2X☐ No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 23845 Speith Road 20636 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🛛 No Specify Specify: 3 Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 Construction <u>Truck Driver</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Garner Blanche Mason permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Mae Garner/Wife injury or other Box 156, Hollywood, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Holy Face Cemetery 02/04/2010 Great Mills, Maryland Signature of meral Serve Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. any M00052 22955 Hollywood Road, Leonardtown, MD Jr. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition ardias Wall Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) onspructice Pulm Prane Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed certificate 1 Yes 2 No or Attending Physician: fter death. funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 🗌 Yes 2 XNo 3 DOA မ ER/Outpatient 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours fter death. To the Funeral Director: After 1 Natural 5 Pending Accident Investigation
6 Could not be 1 Yes 2 No Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3.

Registrar

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DHMH 17 Rev 7/2009

State

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 4 2010

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 0816 A Barbara Jean Glausier 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec 2, 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Pennsylvania **Director** 218-30-9851 75 Usual Residence of Decedent or 28a-f shov ould be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Potomac Street 21713 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2XXMarried Completed by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျပ Alfred C. Zimmerman Jean Shank ii. Page 1 and 2 shous. The Patth and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Glausier Potomac Street Boonsboro, Maryland 21713 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Boonsboro Cemetery 02/11/2010 | Boonsboro, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner S * uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Unichewn that initiated events resulting in death) Last Due to (or as a correquence Physician/Medical The law requires that the death certificate be P.O. Box 68760 , as 1 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Pregnant at time of death Day signed by the and be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? certificate 2 \square No or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 \square Yes 1 Inpatient 2 FR/Outpatient 3 I DOA within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🔲 No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

15H-5

Hospital

State

npleted

Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

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ORIGINAL

appens

certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ra Boonsboro Mp

7, 2010

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

			For State Registrar		State of Ma	aryland		irtment <i>tificate</i>			and M		giene Reg. No.	201	0	0515	9
	Physicia	an	1. Decedent's Nam	ne (First, Middle, Las	t)							2. Date of De Month	ath Day	Yea		3. Time of Death	
	/Medic			Eugene Gav								Februa	cy 5,	2010		11:49 P M	_
	Examin	er		'If not institution, give	street and number)			4b. City, To			f Death			County of De			
~^	Funeral		5. Social Security N	cey Place	ex 7. Age	e (In yrs. la	st birthday)	Fred If Under 1		CK If Under 2	24 Hrs.	8. Date of Bir	th	reder:		ce (State or Foreign	
	Director		213-54-75	560 1	MM 2□F	60	Yrs.	Months	Days	Hours	Min.	(Month, Da Nov. 30	y, Yea <i>r)</i> 1 194	9 Ma		land	
7	2 >		Usual Residence o			40- 01-	7										
-	shov	'n	10a. State	10b. County			Town or Loc	cation							100	I. Inside City Limits 1 ☐ Yes 2 🎇 No	
4	28a-1	Director	Maryland 10e. Street and Nu	Washingt	on	Fred	erick	10f. Zip 0	ode		_		10a Citiz	en of What	Countr		_
1	3a or	ΙΘ	1576 Care					217					_	USA			
1	eau ems 2	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.S	. 13. V	Vas Decede	nt of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.))- 1	4. Race - Ar			
20	is a rank 2 should be lined within 72 hours after bearth with the maryland teath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Fu		ried 2 Married	1 ∐Yes 2 X N If Yes, Give	No		Yes 2		Specify:	, r derto	riicari, etc.)		Black, Wh Specify: W			
3-003b	atural'	ed b	3 Widowed		Year or Dates:		16a. Deced	lent's Usual	Occupa	tion				nd of Busines			
	e. an "ng Madi	Completed	(Spec	15. Decedent's Educify only highest grad	de completed) College (1-4or 5	<u>+)</u>	(Give I life. D	kind of work OO NOT use	done du retired)	uring most	of workii	ng				•	
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	ment of h			☐ Cremation 3 ☐ 5 ☐ Other (Specify		1	enlawn	Mem.	Par	k 02		-2010	Will:	iamspo	rt,	Maryland	
	perimit. Fages I am Department of Heal Important: If item 2 any Injury or other once.		21. Signature of E	uneral Service & curs	see		22.	. Name and	Address	s of Facility	0sb	orne Fi	ınera	1 Home	≥,P.	Α.	
	10 2 W W		23a Part 1 Enter 1	the disease or come	olications that caused	the death								iamspo		MD 21795	
٠	inia		shock, or hea	art failure. List only o	one cause on each lir	ne.		st tile mode	or dyling	, sucii as i	cardiac	ii respiratory a	irest,		10	nterval Between Onset and Death	
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e syacut	al-tran	Examiner	Cause (Disease or that initiated events resulting in death)	s Last	c Due to (or as	a conseque	ence of):								+		
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S de	attending for use a	sician/M	23b. Was deceden	nt pregnant	23c. If yes, outcome 1 Live birth	2 🗀 Fetal	déath 3 □	Ectopic pre					2	3d. Date of o		ay Year	
) g	y the g	ysic	1 ☐ Yes 2 [9 ☐ Unknown	□No	4 ☐ Pregnant at 9 ☐ Unknown	t time of de	ath 5∟	Other (spe	cify)								
r ted	signed by the a	y Phy	Part II. Other sígni	ficant conditions co	ontributing to death bu	ut not resul	ting in the un	iderlying cau	use give	n in Part I.		23e. Did 1	obacco us	se contribute	to the	cause of death?	
aw requires	s been sig should be	ed by										1 🗆	Yes 2	110 3□	Probal	oly 4 🗌 Unknown	
The law requires that the death cert	has be	Completed										24a. Was		24b. Were	autops	y findings available pletion of cause of	
ב ק	After this certificate h funeral director, page	Con										perfo	rmed?	death			
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	ath. r: Afte e fune	ation	1 Datural 2 ☐ Accident	5 Pending investigation	(Month, Day	y, Year)	Injury	м		? es 2 □ N							
VIV.	recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju			et, factory,	office		1	28f. Location (d Number or	Rural	Route Number,	
<u>ב</u> ּ	urs aft rral Di				W.												
Hosp	within 24 hours after death. To the Funeral Director: After this certification in the funeral director, possible telly filled in by the funeral director, p	edical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the best on hiner: On the basis of and manner sta	f examinati	rledge, death on and/or inv	occurred a estigation, i	t the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manner place, and d	ue to t	ted. he cause(s)	
To the	vithin Somple	Mec	29b. Signature and	I title of certifier				29c.	License				29d. Date	e signed (Mo	nth, D	ay, Year)	
5	45		• \		MY	/			Do	06	+9	31	2	1817	0	U	
	4				completed cause of d	eath (Item	23a) (Type, F	Print) Sui	ite	200							
				en Kairou			Chomas	Johns	son	Drive		Frede	rick	MD 21	702		_
	Stat Registra		31. Date filed (Mon	FFR 0 9 21	32. Registra	ais oignatu	6 6	a del	•								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day рм 9:51 Concepcion Velarde Griffith 29, 2010 January 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 8610 Country Club Drive Bethesda Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 □ M 2 🗗 F Days 81 Yrs. 577-86-1241 Feb.11,1928 Guam Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 NYes 2 No Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 8610 Country Club Drive 20817 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 14. Race - American Indian. Black, White, etc. Pacific 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🖾 No Specify: If Yes, Give Year or Dates: Specify: 3₺ Widowed 4 Divorced Islander 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own_Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pilar Torres-Calvo Simon G. Velarde 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theresa Kline/Daughter 8610 Country Club Dr. Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition February 1 Burial 2 Cremation 3 ☐ Removal from State 2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 21. Signature of Fundral Service Licensed MO1315 22. Name and Address of Facility DeVol Funeral Home Kuri 2222 Wisconsin Ave., N.W. Washington, DC 20007 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renal Failure disease or condition resulting in death) Due to (or as a consequence of): 15 Years Diabetes Mellitus Type II Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician / /Medical Examiner

burial-tran

attending physician for use as the buria

signed by the a

certificate has been sirector, page 2 should

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the I within 2 To the I

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Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate because the continuous and the

Records, P.O. Box 68760, O

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be ၉ MD

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

death with the

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

altimore, Maryland 21215-0036

Physician/Medical \$ Completed Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown

1∐Yes 2⊠No 27. Manner of Death 1 X Natural 2 Accident

29a, Certifie

5 Pending investigation 6 ☐ Could not be 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D0057896

29d. Date signed (Month, Day, Year)

February 1, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David W. Hirshfield, M.D. 10215 Fernwood Road #100 Bethesda, Maryland 20817

State Registrar

Medical

31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 0 5 2010 varke

			_ For	State of	Marylan				Mental Hygi	ene	05" 1 6" 1				
			State Registrar			Cei	tificate of	Death		g. No 2 U U	05161				
	Physicia		1. Decedent's Name (First, Middle, Last Maybel	Estel	lle		Griggs		2. Date of Death Month January		3. Time of Death 11:59 PM				
	/Medic Examin		4a. Facility Name (If not institution, give			n		Location of Death	1	4c. County of Deat					
and de			5. Social Security Number 6. Se		7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign				
	Funeral Director			_M 2∏F	82	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 07/29/1	927 Pen	^{uintry)} nsylvania				
	pu ,		Usual Residence of Decedent		100 City	v. Town or Lo	action				10d. Inside City Limits				
	arylar show	'n	10a. State 10b. County Allega	nv	Toc. City		Cumberla:	nd			1 X Yes 2 □ No				
	the M 28a-f notifie	ect	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?				
	th with 23a or ust be	ral Di	626 Brookfield	Avenue				2 1 502		USA					
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, it is a few miner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tes If Yes, Give Year or Da	ces? 2 [X] No e		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🏋 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:					
5	2 hou latura ical E	ted	15. Decedent's Edi	ucation		16a. Dece	dent's Usual Occup	ation		6b. Kind of Business/					
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7	led wi Hygier her th		12	3		Nu Nu	ırse	18 Mother's Nar	ne (First, Middle, M	Private	Duty				
מום	d be fi	Be c	17. Father's Name (First, Middle, Last) Ralph	Henr	y	Werne	er	Hilda	Cathe		Boyer				
<u></u>	should and Ma mark	은	19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	ng Address (Street	and Number or Ri	ıral Route Number,	City or Town, State,	Zip Code)				
<u> </u>	and 2 salth a		Louis C. Griggs /	Husban					, Cumberl		21502				
o e	es 1 a of He of He if item	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from S			sition (Name of matory or other plac			20c. Location - City or					
altimor	. Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)	MD					Flintsto					
סמ	permit Depar Impor any in once.		21. Signature of Funeral Service Dicenses 22. Name and Address of Facility dams Family Funeral 404 Decatur Street, Cumberland, MD												
		8 10	23a. Part Enter the disease, or comp shock, or heart failure. List only of	lications that ca one cause on ea	used the death ich line.	h. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	$\subseteq YF$	4									
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O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 🗆 Feta ant at time of c	Ideath 3	⊒ Ectopic pregnand ⊒ Other <i>(specify)</i> _	sy		23d. Date of de Month	elivery Day Year				
ν., Γ.	s that t ned by e detac	by Ph	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderlying cause given	en in Part I.	23e. Did tob	acco use contribute t	-				
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Vital	ician certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:			Ott		ath (Check only on						
ō	Phys er this eral dii	7: To	1 Yes 2 No 27. Manner of Death	28a. Date (npatient 2 of Injury	28b. Time o	of 28c. Inju	ry at		ence 6 Other (Spo	ecity)				
0	nding tth. :: Afte e fune	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		h, Day, Year)	Injury	M 1 E	k? Yes 2∐No							
DIVISION OF	al or Atte s after des l Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Zee. Place	of Injury - At he	ome, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,				
	e Hospita 24 hours e Funera etely fille	edical (29a. Certifier 1 \(\infty\) Certifying Ph (Check only one) 2 \(\infty\) Medical Exam	ysician: To the niner: On the band mann	asis of examina	owledge, dea ation and/or i	th occurred at the to	ime, date and place opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner a ate and place, and du	as stated. le to the cause(s)				
	To the within To the comp	Me	29b. Signature and title of certifier	. \ ^			29c. Licen			9d. Date signed (Mon					
	3		1/1/	1 - 0 - 0	ista			064167	1	February 1	, 2010				
	nas		30. Name and address of person who Noshin Qaisran	i, M.D.	, 600	Memor	Print) ial Avenu	ie, Cumbe	rland, M	21502					
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 1 2010		egistrar's Signa	sture spark	led								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Laurence Michael Gray 2:39P M Jan. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** sept 19. 1 🟋 M 2 🗆 F Months Hours Min. Wash., DC Director 53 ,1956 578-76-1070 Usual Residence of Decedent shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges District Heights 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death with 3719 Donnell Drive #202 20747 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 XWidowed 4 ☐ Divorced Specify: "natural", Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Roofer 12th Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Laurence Gray Barbara Jean Cook Jage 1 and 2 sh.
Jepartment of Health and Important if item 27 is many injury or other any injury or other 39h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3719 DONNELL Drive #202
District Heights, MD 20747 19a. Informant's Name/Relationship (Type, Print) Shirley Gray/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cem 2/5/10 Suitland, MD Signature of Funeral Servi 22. Name and Address of Facility Austin ROyster Funeral Home 3821 14th Street, NW, Washington, DC 20011 M00996 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Priysician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit Exam Pancytopenia Due to (or as a consequence of): resulting in death) Last -burialattending physician for use as the burial Physician/Medical certificate be Terminal Pancreatic Cancer IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Year Pregnant at time of death signed by the a g Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig 1 Yes 2 No 3 Probably 4 Tonknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 X No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending work М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

68760 Box (P.0. Division of Vital Records,

> State Registrar

Medical

29a. Certifier

only one

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature an

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Suganthi Alagarsamy MD 1500 Forest Glen Rd, Silver Spring, MD 20910

V60

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

January 29,2010

29c. License number

DHMH 17 Rev 7/2009

Registrar

3altimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 7:20 p.M Hankla January Ashe Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** (Month, Day, Year) 11/09/1930 1 ☐ M 23€34 Months Hours 79 Tennesse Director 579-36-0920 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo St. Mary's Piney Point Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20674 USA 44721 Lighthouse Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Maryland 21215-0036 ☐ Yes 2X No Specify: Specify. 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked of ၉ Thomas Ashe Martha Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17408 Piney Point Rd., Piney Point, MD 20674 Barbara Golladay/Daughter Baltimore, | 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot cemetery, crematory or other place) 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 02/04/2010 St. Michael's Ridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Lucral Service process
Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lymphoma Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Pneumonia the attending physician and hed for use as the bunal-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown The law requires that the signed by O Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 8 1 Yes 2 No 3 Probably 4 Unknown Chronic Lymphoma Leukemia Records, completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate Physician: Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Anpatient 2 ER/Outpatient 3 DOA မ this of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t Hospital or Attending 1 Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No death. ☐ Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29d. Date signed (Month, Day, Year) le of certifie 29b. Signature and A 31/10 065312 5 pme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /Sudarshan Siva, M.D. Bethesda, MD 20814 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

FEB 0 2 2010

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MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#7perFH, 2-5-10, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Coleman Robert HANKIN February 4, 2010 Physician/ 11:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Chevy Chase Manor Care Chevy Chase 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 □XM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 87.86 Yrs. Hours Year)1923 Months Washington, DC Director 578-18-5136 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any igury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ft. Washington Prince Georges Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20744 201 Stony Hill Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Å Yes 2 □ No If Yes, Give Year or Dates. WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. white þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Budget Analyst U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Selma Hankin Nathan Hankin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Stony Hill Court, Ft. Washington, MD 20744 19a. Informant's Name/Relationship (Type, Print) Nancy Hankin, Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 N Removal from State 4 Donation 5 Other (Specify) King David Memorial Garden 02/05/10 Falls Church, VA Signatur of Funda Service Licensi TONCTHINSKY SHEBWEW Funeral Home M01008 20012 254 Carroll St. NW. Washington. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director. After this certificate has been signed by i completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Sunitha Bhogavilli, M.D., 9801 Georgia Avenue, #1-17, Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 0 5 2010

32. Registrar's Signature

29c. License number

D 0054566

February 4, 2010

20902

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or					. Ensure A ealth and N	-		Legibl	e.		
	_	For State Registrar	_	State 0	i iviai yiai		rtificate				Reg. No.	201	N	0.5	166
Physicia		1. Decedent's Name Russe		_{Last)} Har	ry	Hi	lleary	, Jr	· .	2. Date of Dea	ath (Pa)	, Yes	3	3. Time o	of Death
Medic Examin		4a. Facility Name (if Western		give street and num. ional Med		enter			Location of Death		4c.	County of D			
Funeral Director		5. Social Security No. 216-22-5'		6. Sex 1 ፟፟፟፝X M 2 ☐ F	7. Age (In yrs. I	ast birthday) Yrs.		Year_ Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 10/25/	v. Year)		Counti	lace (State or ry) rland	or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		Armed For	2 ∑ No 9	S. 13.	Was Deceden If Yes, specify	Cuban	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	ľ	14. Race - A Black, W Specify:		tc.	
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nd 2 shou ealth and n 27 Is m		19a. Informant's Na Rose Anno		p <i>(Type, Print)</i> ary / Wif	`e				nd Number or Run nue, Cumi			Town, State, 2150		ode)	
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permit. P Departm Importar any injur		21. Signature of Fur			27		22. Name and	Address	of Facility Adur Stree	ams Fam	ily	Funera	al .		P.A.
		23a. Part 1. Emert shock, or hear Immediate Cause (I	rt failure. List on	complications that cally one cause on each	aused the deat	h. Do not en	ter the mode o	of dying,	, such as cardiac	or respiratory arr	rest,		- 1	Approxima Interval Bei Onset and	tween
Physician/ Medical Examiner		disease or condition resulting in death)		a. Due to (or as a conseq	uerce of):	LUYY						+	•	
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cate be executed physician and s the burial-transit	Examiner	Cause (Disease or ithat initiated events resulting in death) L	iinjury s	c. Due to (or as a conseq	uence of):									
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 ☐ Feta nant at time of	al death 3	☐ Ectopic pre☐ Other (spec				:	23d. Date of Month		•	Year
uires that the signed by ald be detailed.		Part II. Other signif	icant condition	ns contributing to de	eath but not res	sulting in the	underlying cau	use give	en in Part I.			se contribute			
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I or Atten after deat Director: d in by the	Certificate:	3 Suicide 4 Homicide	Investiga 6	ot be 28e. Place	of Injury - At hong, etc. (Specif)				33 2 2 110	28f. Location (S City or Tow			Rural I	Route Num	ber,
e Hospita 24 hours e Funeral leted filled	Medical	(Check 2	Medical Ex	Physician: To the be aminer: On the basi Nurse Practioner: 1	is of examinatio	n and/or inve	stigation, in my	opinion	n, death occurred a	t the time, date a	nd place,	and due to the	ne caus	se(s) and ma	anner stated.
1		29b. Signature and		2-M	MD	, <u>.</u>	29c. L	icense i				e signed (Mo			
5 Mes		30. Name and addre	ess of person w	ho completed cause	e of death (Item	1 23a) (Type,		200		perlend	mn	2150	1)		
Stat Registra		31. Date filed (Month	h, Day, Year) 0 9 2010	32. Re	egistrar's Signa	ture	11.14	3 0°	1 CUITE	ur will	UIU	N I OC	<u>/ 01</u>		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Naomi HELLER **Physician** 1:45 P M February 6, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 062010 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🗓 F 4, 1922 87 Aug. Director 498-12**-**7877 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Montgomery N. Potomac Maryland EXPIDED FEBRUARY 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code with 1 ms 23a or ? r must be r United States 20878 14070 Saddle River Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after deal Health and Mental Hygiene.
en 21 is marked other than "natural", or items; ther traumatic event, the Medical Examiner muther traumatic event, the Medical Examiner muther traumatic event, 11. Marital Status 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Corrections Parole Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Ellis Levine Jeanne Hudes ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14070 Saddle River Drive, N. Potomac, MD 20878 Elise Ward, Daughter permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other troonce. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 02/08/10 | Alexandria, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Tavetring kyestletenew Funeral Rome 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NAOM Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Was and autopsy performed? Yes 2 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

154 hours after death.

165 Funeral Director; A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 11) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier within 24 ho

To the Fun

completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOEED, DOCKVILLE MD 20852 31. Date filed (Month, Day, Year) State FEB 09 2010 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

		-	For State Of Mary State Registrar		tificate of D			eg. No. 🤈 🕦 📗	05168				
F	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Denis Turner Hannan				2. Date of Deat	y 5, 2010	3. Time of Death 12:15 PM				
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I	Location of Death	rebluar	4c. County of De					
1			Mary s House 5. Social Security Number 6. Sex 7. Age (In	and the state of the A	Rockvil	le If Under 24 Hrs.	8. Date of Birth	Montgome	ery irthplace (State or Foreign				
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nd	show	'n	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Loc	ation				10d. Inside City Limits				
Maryla	28a-f s	Director	Maryland Montgomery	Rockvill					1 🏝 Yes 2 □ No				
/ith the	23a or st be n	ral D	10e. Street and Number 624 Crocus Drive		10f. Zip Code 20850		i i	Og. Citizen of What C United Sta					
death v	items ner mu	Funeral	11. Marital Status 12. Was Decedent Ever	in U.S. 13. W	las Decedent of His Yes, specify Cuban			14. Race - Am Black, Wh	nerican Indian,				
s after	al", or Examit	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Wa	World	☐ Yes 2 🔀 No			Cresit.	White				
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, Mal	m 27 is		Timothy W. Hannan (Son)			<u> </u>							
more	ort of r		20a. Method of Disposition 1 → Burial 2 ─ Cremation 3 ─ Removal from State 4 ─ Donation 5 ─ Other (Specify)		at Heaven lace	Febr	uary 12	20c. Location - City o					
baltimore,	Importar Importar any injur once,		21. Signature of Funeral Service Licensee		Name and Address	s of Facility De	Vol Fune	Silver Spiral Home,					
u 8.6	25 2 2		23a. Part 1. Enjoy the disease, or complications that caused the					thersburg	Approximate				
Pily	sician/	87 6	shock for heart failure. List only one cause on each line. Immediate Cause (Final	ascular A					Interval Between Onset and Death One vear				
<i>j</i> - N	Medical aminer		resulting in death) a. Due to (or as a co	nsequence of):	TO THE STATE OF TH				one year				
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box of death ce	the attend ned for us	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	lelivery Day Year				
that the	ned by a detacl	y Ph	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?				
rds,	een sig rould be	sted t	Diabetes Mellitus						Probably 4 Unknown				
VITAL RECORDS, lysician: The law require	ate has b page 2 sh	Completed by			·		24a. Was a autops perform 1 \(\sum \) Yes	med? prior to death?	autopsy findings available completion of cause of completion of cause of ca				
Ital	certific rector,	Be	25. Was case referred to medical examiner? Hospital:		Otho	ce of Death (Check		-	Assisted ecify) Living				
n OT V ding Phys													
JIVISION OT al or Attending PI	Director:	reet and Number or F , State)	ural Route Number,										
Hospital	Funeral sted filled	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause only one)											
To the	To the compl		29b. Signature and title of certifier	tormy knowledge, d	29c. License			9d. Date signed (Mor	oth, Day, Year)				
2	541		Jon Still	er-		40210		February	0, 2010				
			30. Name and address of person who completed cause of death Dennis Cullen, M.D., 7625 Wis			thesda, 1	Maryland	20814	<u></u>				
	Sta Registra	te ar	31. Date filed (Month, Day, Year) FEB 09 2010 32 Registrar's	Signature	Med.								

Contract of the Contract of th		Physic /Medi Exami	cal
		uneral irector	
	ryland	show],

1 - For State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23a or 28a-f she eny injury or other traumatic event, I'm Wedforl Examine must be notified a gone.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

sicia	an	Wai Lam Hun						Month	Day	Year	3. Time of L	.M
edic		4a. Facility Name (If not instituti	<u></u>	er)		4b. City, Town, o	r Location of Deat	_ January ʰ	28 2 4c. County	2010 of Death	8:50	A
min	er	Shady Grove A					cville			ontgon	nerv	
eral		5. Social Security Number	6. Sex 7.	Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth			lace (State or	Foreign
tor		212-02-1074	1 X M 2 □ F	76	Yrs.	Months Days	HOUIS WIII.	Oct. 20	, 1933	Ch	ina	
		Usual Residence of Decedent 10a. State 10b. Count		10c City	, Town or Lo	cation				10	Od. Inside City	v Limits
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	Director	10e. Street and Number	tgomery			10f. Zip Code		1	0g. Citizen of	What Count		
8		21000 Father	Hurlev Blvd.	#201			0874		_	ed Sta	•	
ST C	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S	S. 13. \	Nas Decedent of H	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Rad	ce - America	an Indian,	
TO THE		1 ☐ Never Married 2 🛣 Ma	Armed Force	s? ∑ No			an, Mexican, Puer Specify:	to Rican, etc.)		ck, White, e	_	
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Olica	ete	15. Decede (Specify only high	ent's Education est grade completed)	7	16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wo	rking	16b. Kind of B	usiness/Ind	lustry	
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H,		17. Father's Name (First, Middle				-		me (First, Middle, i	Maiden Surnar	 ne)		
S eve	To Be	James Hung	, ,				So Me	ei Li				
ury or other traumatic event, the medical Examination is the national	۲	19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	r, City or Town	, State, Zip	Code)	
1 12		Joyce Chan / 1	Daughter		21 Mo	untain La	aurel Cou	ırt,Gaith	ersburg	g, MD	20879	
		20a. Method of Disposition	• II	20b. Pl	lace of Dispo	sition (Name of natory or other play	e) Fob.		20c. Location	- City or Tox	wn, State	
<u> </u>		1 🗗 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (te Par	rklawn rk Cem	sition (Name of natory or other play Memoria etery	20	cuary 3	Rockvi	lle, N	MD	
eny In		21. Signature of Funeral Service	e Licensee	61-	200	Nome and Addre	on of Engility	ne. 10 Ea	st Deei	r Parl	k Drive	2.
5 O		1 RACY A.	Jula.	190111	-			ne, 10 Ea irg, MD 2				
		23a. Part 1. Enter the disease, shock, or heart failure. Lis	st only one cause on each	n line.			ng, such as cardia	ic or respiratory arr	rest,		Approximate Interval Betw Onset and De	veen
an		Immediate Cause (Final disease or condition resulting in death)	a	pirato		lure						
cal ner		roodiang in doddin		as a consequ ce Pano		tic						
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		resulting in death) Last	Due to (or	as a consequ	ience of):							
	Physician/Medical		d									
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8	ian/	23b. Was decedent pregnant in the past 12 months?		h 2 🗆 Fetal	death 3	Ectopic pregnanc	ру			ate of delive onth	-	e ar
3	ysic	1 □Yes 2 □ No 9 □ Unknown	9 Unknow	nt at time of d	eath 5L	Other (specify) _						
neta		Part II. Other significant condi	tions contributing to deat	h but not resu	ilting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of de	eath?
	d by							1 🗆 Y	es 2□No	3 ☐ Prob	ably 4 🔀 U	Inknown
0	Completed							24a. Was a	n 24b.	Were auto	psy findings a	available
90	dwo							autops	med?	prior to cor death?	psy findings a mpletion of ca 2 □No	use of
2	Be C	25. Was case referred to medic	al				26. Place of De	1 □Yes ath (Check only or	2 ØNo	1 ☐ Yes	2 L NO	
		examiner? 1∐Yes 2X∑No	Hospital: 1 X Inp	atient 2	ER/Outpatier	nt 3 DOA Oth	OF:	Home 5 ☐ Resid		her (Specify	y)	
<u> </u>	Ę.	27. Manner of Death 1 X Natural 5 ☐ Pend	28a. Date of (Month,	njury Day, Year)	28b. Time of Injury	28c. Inju Wor	ry at k?	28d. Describe h	ow injury occur	red		
	catic	2 ☐ Accident inves	tigation			M 1□	lYes 2□No					
à l	Certification: To		minod Zoe. Flace U	Injury - At ho etc. <i>(Specif</i>)	me, farm, str /)	eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	l Route Numb	ber,
unpletery miled in by the funeral dire		29a. Certifier 1X Certify	ring Physician: To the be	act of my know	wladae daat	h constraint at the t	mo date and plac	ond due to the	cauca(s) and n		etated	
dieny	Medical		al Examiner: On the basi and manner	s of examina)
<u> </u>	Me	29b. Signature and title of certif				29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)	
) Sur	waty MI			DOO	067386		January	y 28,	2010	
		30. Name and address of perso	n who completed cause of	of death (Item	23a) (Type,	Print)						
		Sonia John, M		edical	Cente	r Drive,	Rockvil1	le, MD 20	850			
Stat		31. Date filed (Month, Day, Yea	r) 32. Reg	istrar's Signat	ure	1.8						
gistra	ār	FEB 02	ZUIU Kento	an fil	4960	The Barrier						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year P М 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Anne Arundel 2606 Hoods Mill Court Apt. 104 Odenton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Feb. 15, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year Days Min. Months Hours 1 □ M 2 🗓 F 81 1928 New York 064-22-8108 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 □ No Maryland Anne Arundel Odenton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. 104 U.S.A. 2606 Hoods Mill Court 21113 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) County School Elementary/Secondary (0-12) College (1-4or 5+) Board Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph La Fauci Ida Bucciero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael D. Helenius/Son 1274 Quaker Ridge Drive, Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Catholic 2/9/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Bowie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) emetery 22. Name an Address of Facility Robert E. Evans Funeral Home, Church 21. Signature of Funeral Service Licensee Jan P. Fre 16000 Annapolis Road, Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final month disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau

Physician

Examiner

10a. State

Funeral

Director

28a-f show

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Director

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examinating the mother an

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or

altimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

/Medical

Examine b Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Permeral Director: After this certificate has been signed by the attending physician and elely filled in by the tuneard director, page 2 should be detached for use as the burial-transit Physician/Medical 2 Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No		26. Place of Death (Check only one)							
		Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Home 5 Residence 6 ☐ Other (Specify)					
27. Manner of Death 1 ★Natural 2 Accident	5 Pending investigation 6 Could not be determined		28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 ☐ Suicide 4 ☐ Homicide		28e. Place of Injury building, etc.	- At home, farm, stree 'Specify)	t, facto	ory, office	28f. Location (Street and Number or Rural Route Num City or Town, State)			

29a, Certifier (Check only one)

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number 00064379 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bestgate Rd Sufe 300 Ampli Rhac 900

State Registrar 31. Date filed (Month, Day, Year) FEB 05

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death FMOTO Physician/ 20100400 M Donald Wayne Ingram Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Washington Hagerstown Washington County Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Sex 1 X M 2 □ F Jan. 19, Months Days Hours Min. ^Y1940 Maryland 70 219-36-3285 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Tes 2 XXVo Maryland Washington Sharpsburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō items 23a or ner must be r Funeral 2250 Dargan Road 21782 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian "natural", or item ledical Examiner n 11. Marital Status Armed Forces? Black, White, etc. þ 1 XX lever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Tractor Operator 10 Be iled \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thomas Ingram Viola Virginia Burgan Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 2735 Harpers Ferry Road Sharpsburg, MD 21782 Andrew R. Gay - Friend (Per.Rep) item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2XXCremation 3 Removal from State Smithsburg Crematory D2-03-2010 4 Donation 5 Other (Specify) |Smithsburg,Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Sign sure of Junera 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC 5hock resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Que to (or as a nonsectioner of) sician and burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d Date of delivery Box (3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Year signed by the aid be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PNEUMONIA VRINARY TRACT INFRECTION law requires 1 Yes 2 No 3 Probably 4 Hinknown Records, Completed RIGHT FOU DIABETES ANEMIA CORDNARY ARTERY DISEASE CHRONIC OSSARCTIVE PULMONARY DISEAS KINNEY DISEASE PERIPHERAL MASCULAR NFECTED 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an LYPRATENSIO cate has I page 2 s DISEASE CHROME VLAZ DISEASE 1 ☐ Yes 2 ☐ No Yes 2 No after death.

Director: After this certific
In by the funeral director, 25. Was case referred to medical Hospital or Attending Physician: of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 19 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -att My D18019 FEB 2, 2010

Registrar
DHMH 17 Rev 7/2009

State

VASIVE

31. Date filed (Month, Day Year)

pare

340 MILL

32. Registrar's Signature

MAGERINOWN MO 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

DATTAMA

			For State AME Registrar		State of MarinF,2/9/10,B	arylan	d / Dep		Health ar	id Mental H		e	n n	517	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Levester Jones 2. Date of Death Month February 3								^{ay} 2010 Yea	r	ne of Death		
C. C.	Examir		4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or Location of Death				4c. County of Death					
-			Prince Ge	Prince George's Hospital Center Cheverly								Prince George's			
	Funeral Director	ı	5. Social Security Number 245–92–3973 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye.) Oct. 29, 19								Birth Day, Year 195	9. E 3 Son	irthplace (S. Country) 1th Can	tate or Foreigi olina	
Dealtimore, Mary Italia Z I Z I D-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine I mat by notified at	and w		Usual Residence o	10b. County		10c. City	y, Town or Lo	ocation					10d. Insi	de City Limits	
	Maryl f sho	ō	Maryland	ŕ	Frince George	·	_	rgo						Yes 2√⊡No	
	r 28a	Director	10e. Street and Nu	mber			3.0	10f. Zip Code			10g. C	itizen of What	Country?		
	h with	a D	2020 St.	. Joseph D	rive	20774				USA					
	ems :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?					Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.			
	or it			1 Mover Married 2 Married 1 Yes 2 No If Yes, Give				1 □Yes 2 ☑ No Specify:							
	hours ural"	d by	3 🗆 Widowed		Year or Dates:								asi a Are a series and a series		
	n 72 "nat	Sete			grade completed)		(Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)			165.1	16b. Kind of Business/Industry			
	withi	Completed	Elementary/Seco	Elementary/Secondary (0-12) College (1-4or 5+) 5+					Roman Catholic Priest			Political man			
	other rent,	BeC	17. Father's Name	(First, Middle, La	st) Johnny Gil	more				Name (First, Midd)	le, Maide	Religious Jaiden Surname)			
/iand	uld be Venta Irked Itic ev	10 E	- Johnnie	L. Jones	carry an	ii Carc			- The l	more McCre					
ar	and fama	ľ	19a. Informant's N					ng Address (Stree	t and Number o	or Rural Route Num	ber, City	or Town, State	, Zip Code)		
∑	and and n 27 n 27 ner tr		Michael W	/. Fisher/	Religious Sup		1		n Avenue,	Hyattsvill	le, M	20782			
ב	Jes 1 t of H If iter or oth		20a. Method of Dis	•	☐ Removal from State	C	emetery, crei	sition (Name of matory or other pla	ice)	Date Feb. 9,	20c. l	ocation - City	or Town, Sta	te	
	tmen tant:		4 □ Donation 5 □ Other (Specify) Gate of					etery 2010				Silver Spring, Maryland			
permit. Pages	permit Depar Impor any In		21. Signature of Fu	uneral Service Li	LCle		f	Name and Addr Cancis J	ess of Facility Ollins F ity Blvd.	uneral Home W., Silver	Inc.	ing, MD 2	0901		
			23a. Part 1. Enter t shock, or hea	the disease, or a	m lications that caused ne cause on each lin	the death	n. Do not en	ter the mode of dy	ing, such as ca	rdiac or respiratory	arrest,		Approx	al Between	
Sq.	Physician		disease or condition	Immediate Cause (Final disease or condition a 5/F5/5										and Death	
1	/Medical Examiner		resulting in death)	1	Due to (or as a	a consequ	uence of):								
Lxammer		ē	Sequentially list co	enditions,	b. Due to (or as a	CONSEGU	ience of).						-		
be executed	uted d Insit	ğ ğ	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	erlying	200 (5) 400 (5)										
	exection and ial-tra	Examiner	resulting in death)	s Last	Due to (or as a	ence of):									
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8	rtifica ng ph as th									A 44		2.5	-		
eath certificate be executed attending physician and for use as the burial-transit	th cer tendir r use	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							23d. Date of delivery					
, -	e dea the at red fo		1 ☐ Yes 2 [1 □ Yes 2 □ No □ □ Idelters 1 □ Other (specify)								Month Day Year			
To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	d by tetach	Phy	9 ☐ Unknown				daine in Abre		e de la Pent I	220 Die	Ltobasso	use contribute	to the occup	o of dooth?	
	δ			s contributing to death but			ifficile						e or deam: 4		
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ָבֻׁ ב	has ye 2 s	ם								aut	24a. Was an autopsy findi prior to completion performed?			ings available 1 of cause of	
VILAI II sician: The	n: Th ficate r, pag		05.14							1 □ Yes	formed?	o 1 □Y	es 2 No)	
	hysician: The law his certificate has t I director, page 2 sl	Be	25. Was case refer examiner? 1 ☐ Yes 2 ☐	1	Hospital:		50/0	Otl	or:	Death (Check only					
5	y Phy er this eral d	7: To	27. Manner of Deat	`	28a. Date of Injur	y T	28b. Time o	1 3 DOA	4 LI NUISI	ng Home 5 Re			pecify)	_	
5	ndting ith: :: Afte e fune	ijo	Natural Accident	5 ☐ Pending investigat	(Month, Day ion	(, Year)	Injury		rḱ?]Yes 2 ∐ No			,			
2	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - At home farm street factory office								28f. Location (Street and Number or Rural Route Number,				
5	rs after all Dir ed in	Certification:	4 ☐ Homicide determined building, etc. (Specify)												
e Hospit: 124 hour: e Funera letely fille		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
1	To the comp	Me	29b. Signature and	title of certifier		_		29c. Licens	se number		29d. D	ate signed (Mo	nth, Day, Ye	ar)	
1	(p		1	MAL	J IMIO			D55220			2	2/3/2010			
7	4				o completed cause of de			Print)		-					
			Terri A. M	ecin, MD	3001 Hospi	tal Di	rive, C	neverly, MI	20774						

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) FEB 0 5 2010

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11.50 JONES JANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City. Town, or Location of Death BALTIMORE BAYVIEW MEDICAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day,) April 27 1953 Pennsylvania 1 🔯 M 2 🗆 F Hours Min. Director 181-42-5740 Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tyes 2 X No Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9865 Lakeshore Drive 20886 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in ILS. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ŏ Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: "natural" 3 Widowed 4 Divorced Black the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any nijury or other traumatic event, the Megonee. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Sales Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shirley Hawkins Robert Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9865 Lakeshore Dr., Montgomery Village, MD. 20886 Rosa A. Jones/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Souls Cemetery 02/04/2010 | Germantown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ TROKES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🗌 Yes 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending (Month, Day, Year, injury Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie RES-DD 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE, BALTIHORE, MD-21224 31. Date filed (Month, Day, Year) State FEB 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 rear 10:06 A.™ Anderson Jackson IIFebruary Benjamin Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Days (Month, Day, Yea, Months Hours Min. 1**X** M 2 □ F Ĩ′921 Virginia 88 **Director** 578-12-3745 Aug. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland Director Prince George's 1X Yes 2 ☐ No Bowie Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must ha Funeral U. S. A. 20720 4305 Hatties Progress Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 💢 No Specify: Yes, Give 3 X Widowed 4 □ Divorced Year or Dates. 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working Public life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Transportation Professional 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P Bridgeforth Mabel Linwood Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4305 Hatties Progress Dr., Bowie, Maryland 20720 Trina J. Ford/Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Barnabas Episcopal 2/9/2010 Upper Marlboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home, Signature of Funeral Service-Licensee 16000 Annapolis Road, Bowie, Mryland 20715 ucil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Arrest Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 🗌 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ျ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nuts Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number D0042853 February 2, 2010 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple Ridgely Ave., Suite 201, Annapolis, Maryland 21401 MD, 62/1Sayan, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** \mathbf{P}^M Edna Catherine King 2010 8:35 Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 204 N. Jonathan Street Washington Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 12/20/1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖺 F 87 220-28-4079 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MDWashington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 204 N. Jonathan Street 21740 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 🛛 No þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nutritionist Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Frank (unk) Crew Janey Rebecca Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 204 N. Jonathan Street, Hagerstown, MD 21740 Department of Health a Important: If item 27 is any injury or other train Constance R. Hunter / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem Park | 02/13/2010 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4 WEOKS disease or condition resulting in death) ANOREXIA /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed ISCENTIC MENINGIT Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No RHEUMATICA 3 ☐ Probably 4 ☐ Unknown ESTIBULAR Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No AMOMA 24a. Was an autopsy performe 1□ Yes 2☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) JUITE 30. Name and address of person who completed cause 346-5 MESICAL CAMPUS -9y Registrar's Signature 31. Date filed (Month, Day, Year) park FEB 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Year Month Day Robert Lee KENDALL 2010 Medical concor 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City. Town, or Location of Death Washington County Hospital Washington Hagerstown 9. Birthplace (State or Foreign Country) Maryland Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1 X M 2 D F Months Days Hours **Director** 216-22-9032 Feb. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 should be filed within renewall and Mental Hygiene.
127 is marked other than "natural", or items 23 48 Wakefield Road 21740 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 X Widowed 4 ☐ Divorced White Completed Year or Dates. 1945-46 Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Printed Cloth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mant. Important: If item 27 is marked any injury or other transponse. ဂ <u>Sherman F. Kendall</u> Ruth Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leisa Kendall - Daughter 480 Mitchell Avenue, Hagerstown, MD. 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 2/15/10 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, MD. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ LUNCO disease or condition resulting in death) und Medical Due to (or as a considuence of) **Examiner** Ore month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and-trar Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Day Year 2 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 🗙 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🗷 No within 24 hours after deau.

y within 24 hours after deau.

To the Funeral Director. After this completed filled in by the funeral director. ည 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

FFB 0 9 2010

DHMH 17 Rev 7/2009

22911

Jefferson Blvd

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Enwert's Medical <u>Virginia Aileen KINGSLEY</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4. County of Death 4b. City. Town, or Location of Death Hagerstown Washington County Hospital Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours 92 Director April 1917 Pennsylvania 214-09-8938 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
The Health and Mental Hygiene.
The Merked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 USA 1040 Matthew Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Midowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teller Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bess M. Thompson permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic to Herbert C. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18710 Dover Drive, Hagerstown, MD. 21742 Phillip E. Metz - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/8/10 Waynesboro, Pennsylvania Green Hill Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 7415 E. Wilson Blvd. Hagerstown, MD. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cauce. Error of darrying Cause (Disease or iinjury Exam that the death certificate be executed that initiated events Due to (or as a resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; to 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

FEB 04

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1832M Krehs 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Manyland Ba Shock Trailme Baltimore City . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F July 22 Months Days Hours Mary land 86 Director 217-14-2169 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 XNo Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21157 USA 1059 Old Manchester Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No 1943 Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White "natural", 3 - Widowed 4 - Divorced 1946 Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) Baltimore Elementary/Seconday (0-12) life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Gas & Electric Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Louise M. Mitchell permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Robert D. Krebs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1059 Old Manchester Rd. Westminster, MD 21157 Wife Ruth N. Krebs Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Lakeview Mem. Park 2/9/2010 Eldersburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lige 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA Westminster, MD Washington Rd. 412 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Intraparenchy mal Cerebral Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day Year in the past 12 months? 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Mumb 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director After this certificate I completed filled in by the funeral director, page Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 5 Pending 1 Natural 2 Accident Fall cliwn Se -30 2010 1500 M 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Royte Number City or Town, State) 10 F, OK, Wax Nusser LXSFMINSKY, MD 21157 determined Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d, Date signed (Month, Day, Year) 29c, License number 3/2010 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) [DUNISE TOWES MD 22 5. GILLAL ST 8 University Of 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Pnysician /Medical Examiner

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Be 2

Box 68760 P.0. of Vital Records,

Hospital or Attanding Division death. To the Hospital within 24 hours a To the Funeral C

> State Registrar

Date filed (Month, Day, Year)

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10-00937 Roy Aleiandro Lacavo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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y Alejandio La	1	- For State Certif	ficate of l	Death			Reg. No.	
Physicia		egistrar 1. Decedent's Name (First, Middle,Last)				2. Date of De Month February	Day Year	3. Time of Death 2258 hrs
al Exami	ner	Roy Alejandro Lacayo	T 45	City, Town, or Lo	ecation of Dea		1, 2010 4c. County of	
		4a. Facility Name (if not institution, give street and number) S/B Riggs Road and Forest Dale Drive	40	Beltsville	ocation of bea	u i	Prince Ge	
		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of B	irth (MM/DD/YYYY)	9. Birthplace (State or
Funeral Director		219-35-2285 1\(\overline{X}\) M 2\(\overline{F}\) 33	Yrs.	Months Days	Hours M	^{in.} 08/19	/1976	Foreign Nicaragua Country)
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eath v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No						
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ours a		13. Decedent's Education (opeon) only the state of	16a. Decedent during mo	s Usual Occupations st of working life.	DO NOT use r	etired)	TOD. KING OF BUG	, and a second second
16 n 72 h nan "r ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Mana	ager			Jiffy L	ube
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215. e filec tal Hy ked or	Be	Justo Lacayo				Moralez		7.0-41
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiers, the file at the annual worked to the rhan "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationship (Type, Print)					umber, City or Town	o. C. 20011
MD d 2 sh lth and n 27 is numat		Christie Lacayo/Wife		tion (Name of cerr		Date Date	20c. Location -	City or Town, State
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imo Page ment c		4 Donation 5 Other Specify:		shington				ervice, Inc.
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Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of)	11					
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	ine	if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause						
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Box 6876 e death certificate the attending phy ed for use as the 1	icial	past 12 months?	=	her (Specify)			1	1
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that the ned by detach		Part II. Other significant conditions contributing to death but not re	saiding in the c	andonying sades s	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 🔲	Yes 2 No 3	Probably 4 🗸 Unknown
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death. The Director: After this certificate has been signed by the funeral director, page 2 should be detach.	은	1 Yes 2 No 28a Date of Injury	28b. Time of		ry at Work?	28d. Descri	be how injury occur	red ck by motor vehicle
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Division of Vital Records, P.O. Box 68760, "To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. "To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deathed for use as the burial - transi			ge, death occu	arred at the time, d	late and place	, and due to the or	cause(s) and manne late and place, and	er as stated. due to the cause(s)
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270	Ž	29b. Signature and title of certifier			.M.E.	OCME	February	
and a		Theoling My King The in	L. D.					
		30. Name and address of person who completed cause of death (Item Theodore M. King, Jr., MD. Assistant Medical E	п∠उब) Examiner	111 Penn S	treet, Baltii	more, MD 21	201	
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	Stati utra	FR (15 7010)	· May	Car.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 6, 2010 9:43 a M ovo 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince George's Laurel Regional Hospital Laurel 8. Date of Birth (Month, Day, You 1y 24, If Under 24 Hrs. 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Year) 1919 Hours 1**™** M 2□ F Months Days Min. Pennsylvania 204-10-1669 90 Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location 10a. State 10h County 1 ☐ Yes 2 XNo Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5705 Luxemburg Street, #101 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 🔣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Specify: White 1 Never Married 2 Married 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Francis Leonard Henrietta Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5705 Luxemburg Street, #101, Rockville, MD 20852 Marguerite A. Leonard/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Feb. 15 Gate of Heaven Cemetery 2010 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Lie ns ins Funeral Home Inc. Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemothorax Due to (or as a consequence of): Atrial Fibrillation Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MRSA Blood Infection Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2\[2\]No 1 ☐ Yes 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

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Director: Af d in by the fur

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Physician

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Funeral

Director

ir than "natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ntt if Item 27 is marked other than "natural", or items 23.

7 is marked other traumatic event,

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau
once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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with the Maryland

Examine Physician/Medical ģ Completed æ

cate has been signed by the page 2 should be detached Certification: To

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. was case referre examiner? 1 ☐ Yes 2 ☑ N	
27. Manner of Death	
1 ★ Natural	5 Pending

tx xinpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be determined

28c. Injury at Work? Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

D

29a. Certifier (Check only one)

29b. Signature and title of ce

Suresh Malik,

2 Accident

4 Homicide

3 Suicide

** **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Legister** Legister** Do not be basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

006628

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

14730 Fourth Street, #327, Laurel, MD 21704

29c. License number

State Registrar Date filed (Month, Day, FEB 09 2010 egistrar's Signature

State Registrar 0 9 2010

29b. Signature and title of certifie



29c. License number

D22035

29d. Date signed (Month. Day. Year)

Janaury 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February of, 2010 130 P Physician/ Lackritz Dorothy Medical 4a. Facility Name (if not institution, give street and number) The Hebrew Home of Greater Washington 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville 9. Birthplace (State or Foreign Country) Ohio If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 🗆 M 2 ី F 0573171920 Director 289-12-1616 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director SBOUNDRY DE 1 XYes 2 No Bethesda Montgomery MD 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ems 23a or r must be r Funeral United States 20816 5705 Rockmere Drive "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married White 1 ☐ Yes 2 ☐XNo 3 😾 Widowed 4 🗌 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any injury or other traumatic event, the Medi College (1-4 or 5+) Elementary/Seconday (0-12) Director of Activities Non Profit 4 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Goldman Abraham Krakoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5705 Rockmere Drive Bethesda MD 20816 19a. Informant's Name/Relationship (Type, Print) March Lackritz - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cleveland, Ohio Lake View Cemetery 02/11/2010 21. Signature of Funeral Service Licenses Edville Pike Rockville MD 20852 23a. Part I. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of physician and s the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s performed? Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: Jethe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 WTROSERRAD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Year Month 30 PM -EWELLING ECI 2010 21 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JOHNS HOPKINS BAY VIEW MEDICAL CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 16, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 D F Months Day, Year) 6. 1937 Davs Hours Min. Tennessee 412-54-7696 Director 72 Usual Residence of Decedent show ttal Hygiene. et other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Taneytown Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 Funeral 459 Second Street USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing 12 Tool & Dye Maker Be permit. Page 1 and 2 should be filed. Department of Health and Mental H-Important: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lettie Lane Carl Lewelling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 459 Second Street, Taneytown, MD 21787 Daniel R. Lewelling, Sr., son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Joseph's Cemetery 02/04/2010 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licenses 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,——shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MULTISYSTEM ORGIAN FAILURE Medical Examiner ABSOMINAL AURTIC Sequentially list conditions Examine at any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: nse yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No ğ Month Year Day Pregnant at time of death the 9 Unknown 9 Unknown P.0. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director. After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 only one 29b. Signature and title of eep 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

4940

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC

31. Date filed (Month

205-000

EASTERN AVENUET, BALTIMOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Franklin Larimore 2010 ٥a /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Dorchester orchester) HOSPItal General Cambridge 8. Date of Birth (Month, Day, Feb. 5, Birthplace (State or Foreign Country) Social Security Number **Funeral** Months 1 □XM 2 □ F Days Hours Min. **Director** 213-14-1314 Delaware Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Dorchester MD East New Market Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5956 Rt. 14 21631 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryes 2 No 6 1 ☐Yes 2 🛣 No Š If Yes, Give Year or Dates: Specify Specify: white WWII 3 Widowed 4 Divorced Hygiene. Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator 12 should be filed w th and Mental Hygier 7 is marked other tt grocery store Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Larrimore Sally Brown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 of Health a Michael Larrimore son P. O. Box 64, Secretary, MD Depertment of Heal Important: If Item 2 any injury or other other. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 2/5/10 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock **Physician** resulting in death) /Medical Due to (or es a consequence of) Examiner Aspirona Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) I□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۵, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐No 24a. Was an After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated To the within 2 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 1 47924 2-2-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOMAN THANWY 503 BYRN CAMBRIDGE MAD 21613 31. Date filed (Month, Day, Year) 32. Registrar's Signature back Registrar

Larn more

Joseph

		For State Registrar		Ce	artment of F	Death	R	Reg. No. 2	0	0518	7
Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of Dea Month	Day '	rear	3. Time of Death	4
/Medic	cal	Elizabeth Jean Myers			4h City Town or	Location of Death	February	1, 2010 4c. County o	f Death	8:40 A	_
Examin	ier	4a. Facility Name (If not institution, gi Hospice House of St. 44724 Hospice Lane	. Mary's			11away		1	. Mai	ry's	
Funeral Director		Social Security Number 6.	Sex 7. Age 1 □ M 2 1 F	e (In yrs. last birthday, 60 Yrs.			8. Date of Birth (Month, Day December	Year) 19, 1949 Z	9. Birthp Coun	lace (State or Foreig tryBalboa Car US Territor	י <i>ף</i> 1a1 y
3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				Tio	od. Inside City Limit	s
other than 'natural', or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ō		Mary's	100. 01.,, 101 0.		ngton Park				1 □ Yes 2 ☑ N	
289	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of Wh	nat Coun	try?	_
1 P		18515 Three Notch Ro	ad		2065	3		Ţ	ISA		
event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	lispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race Black Specify:	White, 6		
CallE		15 Decedent's F	ducation	16a. Dece	edent's Usual Occup	ation		16b. Kind of Bus	iness/Inc	lustry	_
Med	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	life	e kind of work done o DO NOT use retired	during most of world)	king	II 1	-1- C		
	Con	12	3		stered Nurs				Lth Ca	are	
	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam		Maiden Surname)		
	2	Cirilo Hernandez						Panuelos			_
once.	1 9	19a. Informant's Name/Relationship			ing Address (Street					Code)	
	3	Carl D. Myers / Hust	апо		Three Note osition (Name of matory or other place		Date	20c. Location - C		wn, State	_
	12	1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				rebrua	· /	Alovandud	. V.	waini.	
ėj		21. Signature of Funeral Service Line			an Cremator 2. Name and Addre	ss of Facility	2010	Alexandri	a, VI	Igilia	
0		Mychael	Jaroliner		Mattingley P.O. Box 2	-Gardiner 70 Leonar	Funeral Ho dtown, MD	me, P.A. 20650			
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do not en						Approximate Interval Between	
ın al		Immediate Cause (Final disease or condition resulting in death)	. Meta	Static a consequence of):	Breas	ot Ca	ncer			8 years	
er				a consequence or).							
	je	Sequentially list conditions, if any, leading to immediate	b. Due to (or as o	a consequence of).							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C								
		resulting in death) Last	Due to (or as a	a consequence of):							
	edical		d	· · · · · · · · · · · · · · · · · · ·							
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□ Ectopic pregnanc □ Other (specify) _	у		23d. Date Mon		ery Day Year	
	Phy	9 Unknown		ut mat requilibra in the	underhaine en une eis	an in Dark I	220 Did to	shacoo uso contril	auto to th	e cause of death?	
	5	Part II. Other significant conditions	contributing to death bu	it not resulting in the t	underlying cause giv	en in Part i.	1 DY	3/		ably 4 Unknow	/n
	Completed						24a. Was a autop: perfor 1 □ Yes	med?, de	ere autorior to coreath?	psy findings availab mpletion of cause of	ie
	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only or			2010	
	일	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	ent 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 Resid	lence 6 🖸 Othe	r (Specif)Hospice Ho	us
	ü	27. Manner of Death 1- Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry 28b. Time o (, <i>Year)</i> Injury	Worl	k?	28d. Describe h	ow injury occurre	d		
	cati	2 Accident investigation 3 Suicide 6 Could not to	20			Yes 2□No	000 1 1: 10			I Marita Miratan	
	Certification:	4 Homicide determined	building, etc	Iry - At home, farm, st :. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	Street and Numbe n, State)	r or Rura	I Route Number,	
	edical C		thysician: To the best of miner: On the basis of and manner sta	examination and/or i							
5	Med	29b. Signature and title of certifier	and manner sta	illed.	29c. Licens	e number	-	29d. Date signed	(Month,	Day, Year)	_
			6		DAME	50101		02/04	120	10	
}		0130.			1 1 1 1 12	11 11 / X / -			1011	111	
100		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type		50686	<u> </u>	001/07	100	10	
completely filled in by the funeral director, page		30. Name and address of person who 2341.5 Thrope N	completed cause of do	eath (Item 23a) (Type				019	100	70	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februa Blaine Allen Mowen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral **X**M2□F Months Days Hours Min. May 18,1921 214-09-8155 Maryland **Director** 88 Usual Residence of Decedent 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 218 W. Howard Street 21740 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 □ No 1940-Black, White, etc. þ 1 Never Married 2 X Married If Yes Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 1960 Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Aviation Machinist Mate US Navv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Elizabeth Helen Smith Adam Leroy Mowen traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Mowen (Wife) 218 W. Howard St. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Feb.2,2010 Smithsburg, Maryland 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St Williamsport, Maryland 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final Physician men disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Line and Line of death in the past 12 months? signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page death? 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending

or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital

28a-f show

72 hours after death

and Mental Hygiene. is marked other than

Maryland 21215-0036

Baltimore,

3H5+1

within 2 To the I

30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 514

FEB 0

Investigation

determined

6 Could not be

Accident

3 Suicide

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier (Check

Medical

4 Homicide

M.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

21740

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

City or Town, State

DHMH 17 Rev 7/2009

State

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 **Physician** 8:15 p Metz Carl 10 Edmund a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany 721 Haddon Avenue Cumberland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Aug 12, 1937 **Funeral** Months 1 → M 2 □ F Days Hours ΜD 219-34-6379 72 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Allegany Cumberland 1 ☐Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 721 Haddon Avenue Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Payes 2 □ No if Yes, Give Year or Dates: 1955- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene. and the Than 17 is marked other than "natural", or ite may or other traumatic event, the Mealtest Examinatiny or other traumatic event, the Mealtest Examinating or other traumatic event, the Mealtest Examinating or other traumatic event, the Mealtest Examination 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 1955-1959 3 Widowed 4 N Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Kelly Springfield Tire mill room 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Metz Helen (Brinkman) Metz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VA 22947 Keswick Bonnie Farrar daughter 3679 Newbridge Road filem 2 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
Important: If It
any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/12/2010 Rocky Gap Veterans Cemetery MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 Probably 4 Junknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1⊠Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

10 nds

State Registrar 29a, Certifier

29b. Signature and title of certifier

Dr. Paul Snow, Depty Med. Ex., 124 W. 3rd St.; Cumberland, MD 21502 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D09157

29d. Date signed (Month, Day, Year)

02/03/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra MEND #26perMD, 2/9/10, BMW, McCo Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Elizabeth Myers aka Elizabeth Louise Gill Myers 2. Date of Death February Physician/ Day, 2010 3:46 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Morningside House of Ellicott City Ellicott City 9. Birthplace (State or Foreign Country) D • C • 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Aug. 8, 1924 1 □ M 2 🛣 F Hours 85 Director 578-22-0061 Usual Residence of Deceden 28a-f shov flied within 72 hours after death with the Maryland ial Hygiene. d other than "natural", or items 23a or 28a f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🏝 No Ellicott City MD Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 USA 5330 Dorsey Hall Drive, Apt. 220 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xxx No Specify: White Specify: Completed 3 ™ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even and Mental F ျှ Eston Wilmoth Gill Jessie Louise Ryon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7817 Flagstone Court, Ellicott City, MD 21043 Donna L. LaMay/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery Feb 13 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ lespiratery disease or condition Medical resulting in death) Due to (or as a consequence Examiner 10 days Preumana Sequentially list conditions if any leading to immediate Examiner cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congesture heart autoimmune hemolitic 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Depression 24a. Was an cate has page 2 s autopsy performed' this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 - Nursing Home 5- Residence 6 X Other (SpecifiAsst. Living 1 🗌 Yes 2-FNo ျှ 1 Inpatient 2 TR/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) hin 24 hours at er det th.

the Funeral D rector: After thi

upleted filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the F only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 021461 February & 2010 1> Unne us

Registrar

State

4801 Dorsey

Registrar's Signatu

Hall Drive, Ellicott City, ond

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moore

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 ear 1:30 A M **Physician** February Bernard MACK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Collingswood Nursing & Rehab Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Peb. 14, 1922 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Social Security Number 6 Sex **Funeral** Illinois Months 1 M 2 □ F 87 337-14-9379 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the "fedical Exercitiva must be notified at 1 ☐ Yes 2 ☑ No Director **Oconomowoc** Waukesha Wisconsin 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number United States 53066 1078 Timberline Court Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: white 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WW II ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Theater Advertising of Health and Mental Hygis If item 27 is marked other or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked othe any injury or other trainment. 17. Father's Name (First, Middle, Last) Be Belle Harris Irving Mack ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print, 1078 Timberline Ct., Oconomowoc, WI Laurel Kupperman, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Shalom Memorial Park 02/14/10 Arlington Heights, IL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F Licensee Torchtusky shebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner End Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) executed Exami sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day 5 Other (specify) cate has been signed by the apage 2 should be detached to ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 □ Yes 1 ☐ Yes certificate Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examilier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

To the Hospi within 24 hou To the Funel completely fill

31. Date filed (Month, Day, Year) FEB 09 2010 State Registrar

29b. Signature and title of certifie



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) February 3, Day 2010 Physician/ 7:20 p Machlan Joannah H. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Wilson Health Care at Asbury Village Gaithersburg 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Couvinginia Months Hours Feb. 24, 1929 1 🗆 M 2 🛣 **Director** 229-32-0164 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10b. County per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 🗌 Yes 2 🔀 No Gaithersburg Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 20877 407 Russell Avenue, Apt. 407 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White <u>\$</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Real Estate Agent Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bessie Hill William Isaac Hawks 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
407 Russell Avenue, Gaithersburg, MD 20877 19a. Informant's Name/Relationship (Type, Print) Lawrence A. Machlan/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, Metropolitan Crematory) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Alexandria, Virginia Febo15, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Francisch de String Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Day been signed by the sahould be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Gastroesphageal Bleeding Secondary to Unknown Source 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Records, has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 1 No page 2 s Yes 2 No this certificate 26. Place of Death (Check only one) **Division of Vital** director, Be Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 X Natural work' 5 Pending n 24 hours after death.

le Funeral Director: Aft
bleted filled in by the fur 1 ☐ Yes 2 ☐ No M Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F
complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 힏 0105 8 Pebruar

State Registrar 1]165 Stratfield Court, 1st Floor, Marrittsville, MD 21104

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ndidi Feinberg, MQ

31. Date filed (Month, Day, Year) FEB 0 9 2010

		1 - For State Registrer 1. Decedent's Nar	me (First, Midd	lle, Last)		Cei	rtificate of	Death)	2. Date of D	Reg. No	ZUIL	3. Time of Deat
Physic /Medi				Metzbowe	r					Month Februa	Da	ту Year 1, 2010	
Exami	ner			on, give street and n an Villag		h Care	4b. City, Town, o Westmi					: County of De Carroll	
Funeral Director		5. Social Security 186-07-19	970	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs 91	: last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi Aug •	irth Year	1918 Ba	inthplace (State or For
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23e or 28a-f ehov uat be nutities at	i Direc	10e. Street and N 300 St.		ircle, Ap	t. #303		10f. Zip Code 21158					itizen of What C	Country?
adment of Health and Mental Hygiene. ortent: if Itam 27 is marked other than "naturel", or Itame 23a or 28a-f show injury or other treumstic event, if a Medical Examination to an injury or experiment at 8a. 8a.	by Funeral Director		rried 2 ☐ Mar	Armed F	cedent Ever in t Forces? 2 No Give Dates:		Was Decedent of H If Yes, specify Cub			ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	
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fental Hy rked oth tic event	To Be (17. Father's Name Samuel	(First, Middle, Stewar							(First, Middle th Vir		n Sumame) a Clayt	on
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Department of Health a Importent: if itam 27 is eny injury or other treu ODGE.		21. Signature of					Name and Addres						Chapel, 1
ysician		Immediate Cause			1.7	101-01	it.	22-	A ,	- 211000	20		
Medical and spring transit aminer transit	ical Examiner	disease or condit resulting in death fany, leading to cause. Enter Unc Cause (Disease othat initiated even resulting in death	conditions immediate derlying or injury	Due to	o (or as a conse	quence of):	atic k	Bleas	st (Cance	?ρ,		
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			For State Registrar	State of Marylan	-	artment of H <i>rtificate of L</i>			ene 2010	05194
	Physicia		Decedent's Name (First, Middle, Last, Bonnie Jones	Moore				2. Date of Death Month February	Day 2010	3. Time of Death 6:49 p. M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Cambri	Location of Death	2	4c. County of Death Dorche	
	Funeral Director		5. Social Security Number 6. Sec		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 24	9. Birthp Year) Coun	place (State or Foreign otry) Yland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Dorche		ty, Town or Lo		mbridge		1	0d. Inside City Limits 1X Yes 2 □ No
CK+	h with the 23a or 28a 81 be roll	al Director	10e. Street and Number 2603 Lance Drive	9		10f. Zip Code	21613	10	g. Citizen of What Cour	try?
) 980	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medien Evertiner must be rivilled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🙀 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, o Specify: whi	etc.
Maryland 21215-0036	within 72 hor ene. than "natura ne Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done a DO NOT use retired	furing most of work)		6b. Kind of Business/Inc	
_	_ = 0 9	To Be Co	17. Father's Name (First, Middle, Last) Hilby Jones	-			18. Mother's Nam	e (First, Middle, M. Cusick		
, Mary	and 2 shou saith and N 27 is mar er traumai		19a. Informant's Name/Relationship (7) Debbie Willey	daughter	4829	Bucktown	n Road, C	ambridge		}
altimore,	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	rcheste	osition (Name of matory or other place of Mem. Page 1	ark 2/8	Date 2	Oc. Location - City or To	·
Bai	permit Depar Impor any in		21. Signature of Funeral Service Licens		4 -	2. Name and Addres	un St Ca	mbridge.	eral Home P MD 21613	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the dea ne cause on each line. a. Non-small Due to (or as a consec	cel lu	ter the mode of dyin		or respiratory arre	st,	Approximate Interval Between Onset and Death
1		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d						
O. Box 68	ath certi attending or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 NNo 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у		23d. Date of deliv Month	ery Day Year
rds, P.	quires that the de an signed by the a uld be detached f	by	Part II. Other significant conditions co	entributing to death but not re-	sulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute to t s 2 ☐ No 3 ☐ Pro	he cause of death? bably 4 🗆 Unknown
Division of Vital Records,	ysician: The law require is certificate has been si director, page 2 should b	Completed		(y prior to co death? 1⊠No 1 □ Yes	opsy findings available impletion of cause of
<u> </u>	ysicial is certii directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	nt 3 DOA Oth	or:	th <i>(Check only one</i> ome 5 Reside	nce 6 □Other (Speci	T(y)
ion oi	nding Phys ath. r: After this e funeral di	ertification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Worl	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec		reet, factory, office		28f. Location (Str City or Town	reet and Number or Rur , State)	al Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	edical		ysician: To the best of my kn iner: On the basis of examin and manner stated.				rred at the time, da	ate and place, and due t	to the cause(s)
	To the within 7 To the сотры	Σ	29b. Signature and little of certifier	LLL	J.M.	29c. Licens	5 08 6		Ebruary 3	
			30. Name and address of person who o				ambri Due	S am,	1613	
	Sta Regist		31. Date filed (Month, Day, Year) FER 15 2	32. Registrar's Sign	nature	park)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 John M. Martin 7:25 a M February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 222 Stauffer Court Severna Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 17, 1935 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Hours Mary land 212-34-0076 74 Yrs. **Director** Usual Residence of Decedent items 23a or 28a√f shov ier must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 222 Stauffer Court 21146 USA 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? 1 ☐ Yes 2 X No If Yes, Give ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White nem 2/ is marked other than "natural", other traumatic event, the Medical Exal Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 ! Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event than "na once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Dentist/ Self Employed Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Samuel Martin Eunice Mills 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Stauffer Court Severna Park, MD 21146 Ada E. Martin / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Feb. 05, Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, MD 21. Signature of Funeral Service Lice Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. RDIONYOF +THY Immediate Cause (Final ISCHOULD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): YPE ILDM transit the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of attending physician a for use as the bunal-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) Month Day the 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 s this certificate has 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident M Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature & 29c License number 29d. Date signed (Month, Day, Year) 1)35 25 3/2010

Registrar DHMH 17 Rev 7/2009 0. Name and

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

MODICAL PARKWAY SUTTO 100

ANNAPOUS MAZI 401

ddress of person who completed cause of death (Item 23a) (Type, Print)

O LESTE ME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 4, Day 2010 5:07 р м Marie Kearney O'Neill /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Springbrook Adventist Nursing & Rehab. Silver Spring Montgomery 8. Date of Birth July 29, Birthplece (State or Foreign Country)
 New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 M 2 KF Days Hours Min. 157-14-5753 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show ed other than "natural", or items 23s or 28e-f show event, the Medical Examiner must be notified at Virginia Alexandria 1X Yes 2 ☐ No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2317 North Early Street 22302 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pe mit. Peges 1 and 2 should be filed within 7. Deportment of Health and Mental Hygene. I'm crtent: If item 27 is marked other than "na an injury or other freumatic event, if a Modil. 2018. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Kearney Ethel Burns 9a. Informant's Name/Relationship (Type, Print) William E. O'Neill/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2317 North Early Street, Alexandria, VA 22302 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 5, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Part1. Eqt. r the diseast, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur 1. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Cerebrovascular Disease /Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. attending physicien for use as the buris Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. per the 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ End-Stage Renal Disease, Sepsis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death Check onli one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ŧ ٩ 1 ☐ Yes 2 🔼 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending Injury 1 Natural 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D26564 str February 8, 2010 Jusas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Ginsberg, MD 106 Irving Street, NW, Washington, DC 20010 31. Date filed (Month, Day, Year) FEB 09 2010 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas 31 2010 Eugene Price 5:57 p.M January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's Callaway St. Mary's 8. Date of Birth (Month, Day, Year 04/25/194 9. Birthplace (State or Foreign Country) New Jersey Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 🛛 M 2 □ F Min. Hours Director 213-42-5836 66 New Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 22680 Cedar Lane Court, Apt. 20650 <u>United</u> _States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. þ 1 XNever Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Worker Road Construction Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dorothy Elizabeth Price Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie M. Downs/Sister Lanham Lane, Fort Washington, MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Maryland Veterans Cem 02/11/2010 Cheltenham, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Signal e of Juneral Service Licensee Edward N. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Cancer netastati Physician/ resulting in death) Medical embolism Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Spe completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

Division of Vital Records, Cirector

Medical Cutifying Nurse Practicing. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cutifying Nurse Practicing. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22650 Cedar Lane Court, Leonardtown, MD Avani D. Shah, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

(Check

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201°0 11:45 P.M Marv Agnes Powell February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital Olney If Under 1 Year 7. Age (In yrs. last birthday if Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Months Days Hours Min. July 7. **Director** Pennsylvania 199-12-5269 87 1922 Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Derwood 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7432 Oskaloosa Drive 20855 United States permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John McGarry Ellen. McKune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice J. Muller/Daughter 7432 Oskaloosa Drive, Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2010 Alexandria, Virginia Metropolitan Crem. Signature of Funeral Service License 22. Name and Address of FacilityDeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physicians the burial Physician/Medical signed by the a þ Medical Certificate: To Be Completed

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records,

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	elivery Day	Year
	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco 1 ❤ Yes 2	use contribute to		
PNELMONIA		24a. Was an autopsy performed?	death?		of cause of
25. Was case referred to medical examiner?	26. Place of Death (Check of	nly one)	-		
1 ☐ Yes 2 ❤️No	Hospital: 1 Impatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 C Other (Spec	rifiz)	

27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe	e how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		tory, office		(Street and Number or Rural Route Number, own, State)
(Check 2 Medical Examiner	On the basis of examinatio	n and/or investigation,	in my opinion, death occurre	ed at the time, date	cause(s) and manner as stated. e and place, and due to the cause(s) and manner stated the cause(s) and manner as stated.
29b. Signature and title of certifier		2	29c. License number		29d. Date signed (Month, Day, Year)

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		/~/								
30	Name	and add	ress of r	erson wh	n completed	cause of	death	(Item :	23a) (Type	Print)

18101 Passec Plotos Dy, OLNEY

CHUENGULD State Registrar

Registrar's Signatur

24 hours within 24 hor To the Fune completed fil To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physic Medical Exam	ian/ iine	i. Decedent's Name (First, Middle,	Last)					2. Date of D Month		Year	3. Time of I	
A		Lloyd Leva P. 4a. Facility Name (if not institution,		er\		4b. City, Town, o	al antina at D	Month Februar			0510 h	irs
Sec.		5630 Wisconson Avenu		oi <i>)</i>	1	Chevy Cha		eatn		c. County of D Montgome		
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and show	5	Md Montgo	mery	C	hevy Cha	ise					1 X Yes	2 No
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r deat or ite	<u>ٿ</u> ا	1 Never Married 2 X Marr	1 Yes	2 No	""	es, specify Cubar	n, Mexican, Pu	erto Rican, etc.)		White, et	C.	
s afte	<u>۾</u>		ed If Yes, Give Year or Dates:			Yes 2 X No				Specify:	White	
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5-0036 led within 72 hours Hygiene. other than "natus the Medical Exam	Completed	17. Father's Name (First, Middle, La Marx Leva	5+ st)	-	Atto	rney	18.Mother's Na	ime (First, Middle	Maiden	Law		_
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D 21 hould ad Mes is man	ဦ	19a. Informant's Name/Relationship	ımber, Ci	ity or Town, Si	ate, Zip Code)							
MD id 2 sho lith and in 27 is		James W. Hill	/ Husban	1002 CI	nevy	Chase.	Md 208	15				
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is n other traumatic		20a. Method of Disposition 1 **X**Burial 2 Cremation	Removal from 5	20b.	Place of Disposi	tion (Name of cer	metery,	Date	20c.	Location - City	or Town, State	
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other ti		4 Donation 5 Other Spec	fy:	W.	Cemeter	37	F	eb. 5, 10	147.	achinat	on DC	
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		William R. Bugg 23a. Part I. Enter the disease, or confailure List only one cause on	s William	1. Dr	cgg/4513	0 Wisco	nsin Av	e NW Was	hing	ton DO	20016	
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OX 6876 eath certificate s attending phy	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	at time of	2 Feta	I death 3	Ectopic preg	nancy		Month	-	Year
30X death e atte	Physician/N	1 Yes 2 No 9 Unknow		it tillie of	5 Othe	er (Specify)			1			9
O. E at the I by the tached		Part II. Other significant conditions		th but not re	esulting in the un	derlying cause g	iven in Part I.	23e. Did 1	obacco u	use contribute	to the cause of c	leath?
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Vita ysicis his ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2	ER/Outpatient		0.11	sing Home 5	Resider	nce 6 2 Ott	ner: Scene	-
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or At after d Direc	흷	3 ✓ Suicide 6 Could no	28e Place of I	njury - At ho	ome, farm, street,	factory, office bu	uilding, etc.	28f. Location (Street an	d Number or I	Rural Route Num	ber, City
Hospital 24 hours Funcral etely fillec	Certification:	4 Homicide determine	ed (Specify) Mu	ulti-Famil	y Apt.			5030 Wiscom	son Ave	nue, Chevy	onsin Ave Chase, MD	.
4 5 4 E	Medical	29a. Certifier 1 Certifying Physic one) 2 Medical Examine	cian: To the best of mer: On the basis of exa	ny knowledo imination ar	ge, death occurre nd/or investigatio	d at the time, dat n, in my opinion,	e and place, a death occurred	nd due to the caus I at the time, date	se(s) and and plac	manner as st	ated. the cause(s)	
To Yourd	ž	29b. Signature and title of certifier	and manner stated			29c. License					fonth, Day, Year)	
		Jamely Withall or	4)			O.C.N	1.E.		Febr	uary 2, 20	10	
	t	30. Name and address of person who Pamela E. Southall, MD				<u> </u>						
St	ate		Assistant Med	_		Penn Street,	Baltimore,	MD 21201				
Regist	rar	31. Date filed (Meets Bay Year) 20	110 Denew		1. Jan	20						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Jean Rickard 56 Medical 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 24 Avalon Ave. Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Month, Day, Year) une <u>5,1949</u> Months Days Hours 1 🗆 M 2 💢 F Director 60 220-52-1557 June "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Avalon Ave. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Never Married 2 🕱 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 is of Health and Mental Hygiene.
If item 27 is marked other than "r pr other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Server Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond P. Eichelberger, Sr. Julia V. Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Rickard/Husband 24 Avalon Ave., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hall Important: If ite any injury or ot . Page 1 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 2/5/2010 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): executed signed by the attending physician and I be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes 2 No 3 Probably 4 Unknown eral Director: After this certificate has been s filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD Name and address of person who completed cause of death (Item 23a) (Type, Print) SH 3

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBruar Physician/ 20°10 1010 M Gerald Elmer RENNER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington <u> Washington County Hospital</u> Hagerstown 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 1 Å M 2 □ F Months Davs Hours Min. 1946**Director** 63 Màrch 217-42-8884 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tes 2 No Maryland Washington Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 8406 Mapleville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 M Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify. 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 0 Laborer Construction d 2 should be filed wi lath and Mental Hygie n 27 is marked other er traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Goldie Agnes Hutzell Paul Elmer Renner Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8406 Mapleville Road, Boonsboro, Md. item 2 <u> Donna Renner - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/8/2010 Hagerstown, MD Lawn Mem. Park 32. Name and Address of Facility Minnich Funeral Home Signature of Funeral Service Licens 415 E. Wilson Blvd. Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and reath Immediate Cause (Final HEMORRHAGE STROKE Physician/ EFT day Medical resulting in death) Due to (or as a consequence of) Twombus Atrial Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2: No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 🗌 No nvestigation Accident
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State

Baltimore,

DHMH 17 Rev 7/2009

Registrar

соmpleted

To the l within 2 To the l

Medical

29a. Certifier

(Check

only one)

HABIB

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB () 5

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C-HOTANI

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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E ANTIETAM ST, HAGERSTOWN, MD 21740

29d. Date signed (Month, Day, Year)

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Keith Repine Month 2010 1:27 P February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign
Country) 1 🔀 M 2 🗆 F Months Hours Min. 62 184-36-1724 Pennsylvania **Director** Sept. 1947 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Germantown 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13000 Waters Discovery Lane 20876 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1967

If Yes, Give 1071 Black, White, etc. ≥ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced White 1971 Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Car salesman Automobile 27 is marked other traumatic event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file if Health and Mental I-item 27 is marked of ည Edward Repine Marian Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Suanne C. Repine - Spouse 13000 Waters Discovery Lane, Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, compatory or other place)
Metropolitan
Crematory 1 Burial 2 X Cremation 3 Removal from State February 4 2010 4 Donation 5 Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Lip RACIPOTUNI MOIII 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and De Minutes Physician/ Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Minutes Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be 68760 IF FEMALE 23b. Was decedent pregnant Box (23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No funeral director, page 2 certificate 25. Was case referred to medical examiner? Be Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred After X Natural 5 Pending injury n 24 hours after death.

e Funeral Director: After the function is a second to the function in by the function is a second to the second to the function is a second to the function is a second to the second to th 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the least of the state of the cause(s) and manner stated.

2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Packforer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 3, 2010 00068207 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vipul Kella, M.D., 9901 Medical Center Drive, Rockville, MD 20850

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nonth Day Pebruary 02, 2010 **Physician** John F. Rowe, Sr. 07:50 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg Village Nursing Care Center Frostburg If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F Yrs Maryland January 12, 1918 214-07-1545 92 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar in ust be notified at 1 ☐Yes 2 No Director Allegany Cresaptown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12811 Meadow Avenue, S.W. U.S.A. 21502-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Myes 2 No W W II
If Yes, Give
Year or Dates: Keyea 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 INo Specify: Specify: White 2 3 Widowed 4 Divorced Kerea Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineer electric utility company 12 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 17. Father's Name (First, Middle, Last) Be Mary Stark Benjamin Franklin Rowe ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) L. Pages 1 and 2.Artment of Health artificial art West Virginia 25411-Mary Beth Weber daughter 98 Sunset Drive Berkley Springs 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If its any injury or o 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Cumberland Maryland February 03, 2010 Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Lichola 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAITURE MONTHS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MENTIA Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Exami e, Zure and Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Vear Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performe 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred I or Attending F after death. 5 Pending investigation 1X Natural 1 ☐ Yes 2 🗆 No neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 624 hours a To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
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31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death, (Item 23a) (Type, Print)

62. Registrar's Signature

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FEB 0 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2010 10:00 p M February <u>Sandra D. Rolef</u> /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silver Spring Montgomery 612 Symphony Woods Drive 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) 03/19/1950 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 ☐ M 2 🖾 F 59 104-44-9961 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Weden Examined must be notified at once. 1 Tyes 2X No Silver Spring Director Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20901 USA 612 Symphony Woods Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 □Yes 2 🔀 No Black, White, etc. 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 287 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 5+ Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Michenbaum Gerald Soklow ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 612 Symphony Woods Drive, Silver Spring, MD <u> Steven A. Rolef - Husband</u> 20c. Location - City or Town, State 20a Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery: 02/09/2010 Adelphi, Maryland 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. Signature of Funeral Service Licensee M01255 | 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or it art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years a Ovarian Cancer (Peritoneal) disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 5 Other (specify) P.0. the 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate I 1 ☐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 ☑ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0040102 February 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Silver, MD, 2150 Pennsylvania Avenue, NW, Washington, DC

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 09 2010

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** Pauline Elizabeth Reeder FEBRUARY 10, 2010 5:00A.M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Washington Boonsboro If Under 8. Date of Birth (Month, Day, Year) Aug 3, 192 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral Hours Months Days 1 □ M 2 👿 F Min. Director 219-20-0700 82 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Inc Medical Examinor must be restlind at 1**X**□Yes 2□No Director Maryland Washington Boonsboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 110 D Orchard Drive 21713 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0wner Raspberry Farm permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Shank Rankin Frances Davis Marv 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charleen M. Jones / Daughter 6529 Old National Pike Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery 02/15/2010 Boonsboro, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 23a. Part 1. If ter the disease, or complet tion, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only of cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYUCARDIAL INFAMILION IHR /Medical Due to (or as a consequence of): **Examiner** HISTORY OF MONTHS ALUCYTHMIAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 15LITTEMIL that initiated events resulting in death) Last CANDIOMADPIARE MONTHS sician and burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Hinknown 9 Unknown signed by Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a

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AMD:

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760,

State Registrar

completely

within 2

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. GHAZALA OADIR.

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FEB 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713

29c. License number

1)4656

29d. Date signed (Month, Day, Year)

2010

301-432-8470

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20020 Catherine 11:59 PM oria 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Brooke Grove Assisted Living - Woods 1612 Sardy Montgomery Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 167-12-5257 1 □ M 2 🗓 F Days 4/125/11922 Hours Pennsylvania 87 Director Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d, Inside City Limits Director Maryland Montgomery Sandy Spring 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1612 Hickory Knoll Road 20860 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other to any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Albert Ciesielka Mary Stossel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Mary Rajca (Daughter) 1215 Perry Street N.E. Washington D.C. 20017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crem. 2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, urtes MD 20877 23a. Part 1. Enter the disease, or complications wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial in Duelo (or as a consequence of) Physician/ disease or condition MINUTES Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetai uea.
Pregnant at time of death
Unknown 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day signed by the a d be detached for 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obstructive pulmonary disease; hyper-1 Yes 2 No 3 Probably 4 Unknown tension; congestive 24b. Were autopsy findings available prior to completion of cause of death? heart tailure 24a. Was an has autopsy certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No assisted city) living Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 Yes 2 No Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier us attending physician

State

Registrar

Box 68760

P.O.

Division of Vital Records,

Stade

School Road Sandy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.D. 18100

32. Registrar's Signature

Stace Brookettuffman

FEB 02

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Himpre Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min. 1 □ M 2 🔀 F Months Hours -30-5838 Director Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No ADAMS GETTYSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral RILEY 17325 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RICHARD 七. SMITH RITH MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENIKE DAUGHTER NEW OXFORD, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1. Burial 2 Cremation 3 Removal from State 2-2-2010 4 Donation 5 Other (Specify) GETTYSBURG FRANCIS CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 321 CARLISUE ST. 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ohysician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown for Month Pregnant at time of death 5 Other (specify) signed by the aid be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 🗷 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 XNo ၉ 1 🄀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physisithin 24 hours after death.

To the Funeral Director: After this of 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: T. the best of my because(s) a best occurred at the time. See and due to the cause(s) and manner as stated. (Check My one 29b. Signa 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month 32. Registrar's Signature State Registrar

Division	To the Hospital or Attending I within 24 hours after death.
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	•	State Registrar					Ce	rtificate of l	Death		Reg. No.	2010	1, 0520
ician	1. D	ecedent's Nam								2. Date of Dea	Day	Year	3. Time of Death
cal			Chomyk					41. Olt. Town	- Landing of Dooth	Februar		2010 ounty of Deatl	9:25 A M
ner	4a. I	acility Name (Calver	it Coun	_			r		Location of Death Frederi			lvert	'
-	5. S	ocial Security N		6. Sex			. last birthday)	If Under 1 Year Months Days			th v. Year)	9. Birti	hplace (State or Foreign untry)
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3		Marital Status			. Was Dece Armed For 1 ∐Yes	dent Ever in l ces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14	I. Race - Ame Black, White	
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5	_	LZ Father's Name		Lact)			Sale	s Associa	18. Mother's Nar	ne (First, Middle		e Remod	leling
De De		Fathers Name Constan	•		a					wasnycia			
2	-	ı, Informant's N					19b. Mail	ing Address (Street				Town, State, 2	Zip Code)
			Shaugh			hter	3949	5 Pocahah	ontas Dr	ive. Med	hanio	csville	, MD 20659
	20a	. Method of Dis	sposition			20b.	Place of Disp cemetery, cre	osition (Name of matory or other place	ce) F	ebruary	20c. Loca	ation - City or	Town, State
		4 ☐ Donation			movai irom s	Br		ld-Echols		2, 2010			Hall, MD
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	Par			ions contr	ributina to de	eath but not re	esulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco us	se contribute to	o the cause of death?
δ P					Ü					1 🗆	Yes 2□]No 3□P	robably 4 🗆 Unknown
ere										24a. Was		24b. Were a	utopsy findings available
Completed	Г									auto perf 1 □ Yes	ormed? 2 X No	death?	completion of cause of s 2 □ No
Be C	25	Was case refe examiner?	erred to medic	al					26. Place of De	ath (Check only			
		1 Yes 2		Ho				SIIL 3 LI DOA		Home 5 ☐ Res			ecify)
Ön:	27.	Manner of Dea	5 Pend	ing	28a. Date (Mon	of Injury th, Day, Year)	28b. Time Injury	Wo		28d. Describe	how injury	occurred	
icati		2 Accident 3 Suicide	6 ☐ Could		28e Place	of Injury - At	home, farm, s	treet, factory, office]Yes 2□No	28f. Location	(Street and	l Number or F	tural Route Number,
Certification: To		4 Homicide	deter	mined	buildi	ng, etc. (Spe	cify)	,			wn, State)		
	29	a. Certifier (Check only	1 X Certify 2 Medica	ing Physi	er: On the b	asis of exami	nowledge, dea	ath occurred at the investigation, in my	time, date and place opinion, death occ	e, and due to the	e cause(s) , date and	and manner a	as stated. e to the cause(s)
Medical	20	one) b. Signature an			and man	ner stated.			se number				th, Day, Year)
Г	20	b. Olgitatal o'an	1116	۵.	1 2	10-		D	0068923		02	102/	2010.
	30.	Name and ad	dress of perso	n who con	npleted caus	se of death (It	em 23a) (Type	e, Print)				- 5(NO LO
								Rd., Sui	te 300, 1	Prince F	reder	cick, M	D 20678
	21	Date filed /Mr	onth, Day, Yea	r)	32. F	gistrar's Sig	nature						
tate trar	31.	Date filed (Me	ren (1 00	10 1		A	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:00^A M **Physician** 2010 February 4, Cleo William Stack /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's 24496 Joy Chapel Lane Hollywood 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 € M 2 □ F 90 Yrs. 577-28-1442 Maryland September 25,1919 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatih and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ant or other traumatic event, If a No Jone Examiner must be notified at any or other traumatic event, If a No Jone Examiner must be notified at 1 □Yes 2 No Hollywood St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20636 USA 24496 Joy Chapel Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Union Steam Fitter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Seiberlich Charles Stack ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24496 Joy Chapel Lane, Hollywood, Maryland 20636 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once. Cleone M. Wible / Daughter 20b. Place of Disposition (Name of cernetery, crematory or other place)
Charles Memorial 20c. Location - City or Town, State 20a. Method of Disposition February 9, 1 Burial 2 □ Cremation 3 □ Removal from State Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Gardens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home 21. Signature of Funeral Service Licer P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death XIHG-OSC KAPOTIC Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an autopsy 2 - No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death After 1 Natural 5 Pending investigation in 24 hours after death.
The Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D56096

State Registrar

31. Date filed (Month, Day, Year)

RAJBINDER

32. Registrar's Signature

FR 0 5 2010 Reven B. Salls

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SMAN ASSOCIATES, LEONARD TOWN

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Walter Jack Sweeney 14/0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F July 22 Mary Tand ^{rear}934 Director 217-28-1056 75 Usual Residence of Decedent show "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Washington County Hagerstown 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 333 Mill St. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates the M dical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Man Elementary/Seconday (0-12) College (1-4 or 5+) Painter Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter E. Sweeney Admer Childress Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Jones-sister 167 Stotlemyer Lane Martinsburg, WV 25405 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rose Hill Cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2-5-2010 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition hvan. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a detached t 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗌 No 1 Yes Yes within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-4+ AR 31. Date filed (Month, Day Year) 4 2010 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2-3-2010 **Physician** 1:00а м Richard Edward Seibert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 12229 Funkhouser Road Clear Spring, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-11-1936 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 73 217-32-6142 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinations to incitifue at MD Washington Clear Spring Director 1 ☐ Yes 24 ☐ No 10e. Street and Number 12229 10f. Zip Code 21722 10g. Citizen of What Country? U.S.A. Funkhouser Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: white ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within thand Mental Hygiene.
7 Is marked other than "r Ribbon mfq.co. Elementary/Secondary (0-12) College (1-4or 5+) shipping dept. 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Seibert Evelyn Simler ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If item 27 is any Injury or other trau Paulette J.Seibert wife 12229 Funkhouser Rd. Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Cem. 20c. Location - City or Town, State 20a. Method of Disposition. Burial 2 Cremation
4 Donation 5 Other (5 3 Removal from State Hagerstown, MD 5 ☐ Other (Specify) / 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, immediate Cause (Final Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a con quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the aftending ph for use as th IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 1 □Yes 2 □ No. 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate I 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1NG or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 INO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 5 Pending investigation 1 Natural within 24 hours atter usau...
To the Funeral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and margner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month

3H-5

WY

strar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State of	of Maryla	and / Dep					•	001	0	05012
1. Decedent's Name (First, Middle, Last) Certificate of Dea							11	2. Date of De	Reg. No	0./	U	3. Time of Death		
Physici Med		February 4, 2010									¹⁹ 2010 Yea	ır	10:15 a M	
Exami	ner	4a. Facility Name (if I			nber)		4b. City, Tov	4b. City, Town, or Location of Death			40	. County of D	eath	
Funera	Т	6010 Johnson Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last b				s. last birthday)	Bethesda iirthday) If Under 1 Year If Under 24 Hrs.			8. Date of Bir			Gomery Birthplace (State or Foreign	
Directo	_	213-56-918		1 □ M 2 🔀 F	92	Yrs.	Months D	Days Hou	rs Min.	œE. 10	, Year)	17	Country) D.C.	
show dat	٦,	Usual Residence of I 10a. State	Decedent 10b. County		10c.	City, Town or Lo	cation						10	d. Inside City Limits
Maryla 8a-f s tified	lect(Maryland		Montgome	ry	Bethe	sda.							1 ☐ Yes 2 ☐ X No
h the la or 2 be no	<u>=</u>	10e. Street and Num					10f. Zip Co	ode			10g. Ci	tizen of What	Count	ry?
ath wit ms 23	Funeral Director	6010 Johns	son Avenue	12. Was Dece	adopt Ever in	118 112		20817	Origin? (Spo	point Vog or No	US			In the second
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 sho other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Marrie 3 😾 Widowed 4		Armed Fo	orces? 2 🔀 No /e		If Yes, specify Yes 2	Cuban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Al Black, W Specify:	hite, et	tc.
5-0 hours	plete		15. Decedent's	Education		16a. Dece	dent's Usual O	occupation	nost of worki	ing	16b. K	(ind of Busine	nite ss Indu	
2121 within 72 giene. ner than t, the Me	Completed	Elementary/Seco					(Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant				Re	etail		
nd 2 filed will al Hygio d other	Be	17. Father's Name (F)				18. M	other's Name	e (First, Middle,	Maiden			
Narylane should be file and Mental I is marked o raumatic eve	₽	Matthew Y	Yingling					Lo	uise Ha	rrington				
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		19a. Informant's Nar John Danie				1	_			l Route Numbe er Spring			Zip Co	nde)
or Health fitem 27		20a. Method of Dispo	osition			b. Place of Dispo	sition (Name o	of	; ,	Date		ocation - City	or Tow	/n, State
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.			Cremation 3 5 Other (Spe		State 0	edar Hill	ceme ter		Feb. 201		Sui	tland, M	⁄ary	land
Baltimo permit. Page Department of Important: If any injury or once.		21. Sign vure of Fun	era/Service Lice	F Cole			Name and A Francis 500 Univ	J. Coll	ins Fun	eral Home	e Inc r Spr	ing, MD	209	01
	a 1)	23a. Part 1. Enter the disease, or convolcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											1	Approximate Interval Between
Physician	100	Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Accident Due to (or as a consequence of): Hypertension Due to (or as a consequence of):												Onset and Death 3 months
Examine														
	iner													
ecuted and -transi	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):								+				
Box 68760 death certificate be executed re attending physician and ed for use as the burial-transit	edical E	Atrial Fibrillation												
8760 tifficate b	Med	IF FEMALE:		_ u										
BOX 68 death certifi he attending led for use a	ian/	23b. Was decedent p			Birth 2 F	etal death 3					136	23d. Date of Month		y Day Year
	Physician/M	in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4 □ Preg g □ Unki	nant at time	of death 5 L	Other (special	<i>ty)</i>				WOTH		ray real
P.O. s that t	by P	Part II. Other signific	cant conditions	contributing to d	eath but not	resulting in the	inderlying caus	se given in P	art I.					cause of death?
rds, equire een si	eted													ably 4 Unknown
Division of Vital Records, P.O. Box 68, tal or Attending Physician: The law requires that the death certific rs after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Completed											prior t death	o com	sy findings available pletion of cause of
ital sician: certific	Be	25. Was case referred examiner? 1 \sum Yes 2 \sum x		Hospital:				Other:	Death (Check		_	_		
Of V g Phys er this neral di	e: To	27. Manner of Death		28a. Date	of injury	28b. Time o	28c.	Iniurv at		me 5 🔀 Resid 28d. Describe h			ecify)	
ION tendin eath. or: Aft the fur	Certificate:	1X Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigation 6 ☐ Could not	on	th, Day, Year)	injury		work? 1 ☐ Yes 2	□ No					
JIVIS al or Att s after d I Direct d in by		4 Homicide	determine	28e. Place	of Injury - At ng, etc. (Spec	home, farm, str cify)	eet, factory, of	fice	Į:	28f. Location (S City or Tow			Rural Fi	'oute Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 (Check 2 only one) 3		ysician: To the b niner: On the bas irse Practioner:	sis of examina	tion and/or inves	tigation, in my o	opinion, deatl	h occurred at	the time, date a	nd place	, and due to th	e caus	e(s) and manner stated.
vithi 170 th		29b. Signature and ti	itle of certifier	1.0			29c. Lic	cense numbe	er		29d. Da	te signed (Mo	nth, Da	ıy, Year)
3		10	bent	- 1 -	2 m	>		D31:	282		Feb	ruary 4,	201	ſΟ
		30. Name and addres				em 23a) (Type, F in Avenue,		Bethesda	a, MD 20	0814				
Sta Registi		31. Date filed (Month)		046 A	egistrar's Sig	nature	ales.							

10-00950							
Joseph Sela							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

sepn Sela		State of Maryland / Department of Heal 1- For State Registrar Certificate of Deal		, 0	2010	05213						
Physici ledical Exami		Decedent's Name (First, Middle,Last) JOSEPH G. SELA		2. Date of Deat Month February 2	h Dav Year	3. Time of Death 1035 hrs						
· 14.			r, Town, or Location of Death enbelt	1 cordary 2	4c. County of Death Prince George	's						
Funeral Director		<u></u>	nder 1 Year If Under 24Hrs.	_	h(MM/DD/YYYY) 9 Birt	nplace (State or						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
* .	jo.	Maryland Prince George's Greenbelt				1 XYes 2 No						
the Mary a or 28a- otified at	Director		Zip Code 20770		og. Citizen of What Cour United Stat	,						
r death with or items 2	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spe	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto		White, etc.							
ours after atural", aminer	ρ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu	2 X No specify: al Occupation (Give kind of w		Specify: Whi							
MD 21215-0036 2 should be supposed that the Maryland hand Month High with 12 hours after death with the Maryland hand Monthal Hygieweith 12 hours after a 71 is marked other than "matural", or items 23a or 28a-1 she smatte event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Meteorolog	vorking life. DO NOT use retir gist	,	National We	eather Svc.						
MD 21215-0036 d 2 should be filed within 72 thth and Mental Hygiene. n 27 is marked other than 's numatic event, the Medical	Be	17. Father's Name (First, Middle, Last) Moshe Greenstein	18.Mother's Name Fannie	(First, Middle, M Billig	laiden Sumame)							
AD 21 2 should h and Me 27 is ma	J.	_ · · · · · · · · · · · · · · · · · · ·	ss (Street and Number or Related Hill Road (
무 정 등 표 등		20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Normation) or other place of Disposition (Normation) or	ce)	Date 4/2010	20c. Location - City or Alexandria,	,						
Baltimore, permit. Pages 1 an Department of Het Important: If ite		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	d Address of Facility and the Borgward t	Funera	1 Home, PA							
Physician		23a. Part I. Enter the disease, or implications that caused the death. Do not enter the modifailure. List only one cause on each line.	Powder Mill Ro e of dying, such as cardiac or			Approximate Interval Between Onset and						
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Intr-oral Gunshot Wound Due to (or as a consequence of):				Death						
	-ie	Sequentially list conditions.										
5	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):										
\$8760, rtificate be executed ing physician and as the burial - transi	cal E	d. UNPENDED AMENDED			 .							
	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy			23d Date of delivery							
tal Records, P.O. Box 6876 cian: The law requires that the death certifical certificate has been signed by the attending ph ector, page 2 should be detached for use as the	Physician/N	past 12 months? 1 Live birth 2 Fetal deat 4 Pregnant at time of death 5 Other (St.		ncy	Month D	ay Year						
P.O. E P.O. E so that the d gned by the ce detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.		bacco use contribute to t							
ds, P, equires the een signe	eted t	Bladder cancer		1 Yes		opsy findings available						
Records, The law requir	Completed			autops perform 1 V Yes 2	med? death?	empletion of cause of						
Vital Red hysician: The this certificate	o Be (25. Was case referred to medical examiner? Hospital: I Inpatient 2 ER/Outpatient 3	26 Place of Death (Check of DOA Other Nursing		Residence 6 🗸 Other:	Scene						
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Division Division pital or Attendit ours after death reral Director: A	Certification:	2 Accident Investigation 5 Feb 2, 2010 1036 hrs 28e Place of Injury - At home, farm, street, factor (Specify) Multi-Family Apt.		or Town, St	treet and Number or Rur ate) oad, Unit G, Greenbe							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the control of the control	he time, date and place, and	due to the cause	e(s) and manner as state	d.						
To To	Me	and manner stated. 29b. Signature and title of certifier	9c. License number		29d. Date signed (Mon	th, Day, Year)						
43		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		February 3, 2010							
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Bal	timore, MD 21201									
St Regist	ate rar											

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mosterl Examinat risust be notified at once. Baltimore, Maryland 21215-0036 **Physician**

	/M	edica
	Exa	mine
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		For State		State of M	laryland.			lealth and N	<i>l</i> lental Hy	gien	e2010	05214		
		Registrar	o (Eirot Middle 1	41		Cei	tificate of	Death	2. Date of De	Reg. No.				
Physicia /Medic		1. Decedent's Name Jane	e (First, Middle, La	,	LeNore			Schwab			y Year 20 1 0	3. Time of Death 12:30 P ^M		
Examin			evre Roa	ve street and number) Sex 7. Age (In yrs. last birthday)			4b. City, Town, or Cumbe	8. Date of Bir		Alle				
irector		297-14-4 Usual Residence of	055	1□M 2 X F	88	Yrs.	Months Days	Hours Min.	01/04	/192	2 0hi			
a-f show	ctor	10a. State MD	10b. County All	egany	10c. City, Town or Location cany Cumberland						10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
23a or 28 ist be not	al Director	10e. Street and Nur 400 L	^{nber} eFevre R	oad			10f. Zip Code 21	502		10g. C	itizen of What Cou USA	intry?		
al", or items	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2 🔀 Married 4 □ Divorced	12. Was Deceden Armed Forces 1 XYes 2 If Yes, Give Year or Dates	? ^{]No} 1943	- !	Was Decedent of H f Yes, specify Cuba ☐ Yes 2 🔀 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.))-	14. Race - Amer Black, White Specify:			
Department of Health and Mental Hyglene. Important: If lies ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinational beneathed once.	Completed	Elementary/Seco	15. Decedent's E cify only highest gr ndary (0-12)	ade completed) College (1-4or	1940 16a. Decedent's Us (Give kind of w life. DO NOT 16a. Decedent 1			vork done during most of working use retired)			Kind of Business/li			
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h and me 7 is mark traumatio	으	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mailir	g Address (Street	and Number or Rur	ral Route Numb	er, City	or Town, State, Z	ip Code)		
ent of Healt it: If item 27 y or other 1		Doug Schwab / Son 835 MacDonald Terrace, Cumberland, MD 20a. Method of Disposition 1 Paurial 2 Cremation 3 Removal from State 835 MacDonald Terrace, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of cemetery, crematory or other place)								ocation - City or T				
Importar any injur once.		4 □ Donation 5 □ Other (Specify)												
rian and ledical aminer rial-transit	Examiner	23a. Part 1. Entects shock, or hea Immediate Cause (disease or condition resulting in death) Sequentially list confirmed in the cause. Enter Under Cause (Disease or that initiated events resulting in death) I	rt tallure. List only (Final n nditions, mediate rlying injury	Due to (or a	ad the death. If the death in a consequent is a consequent in	ice of):		g, such as cardiac	or respiratory a	urrest,		Approximate Interval Between Onset and Death ONE YEAR		
within 24 itous are treatil. The Funeral arectors After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of deli Month	very Day Year			
en signed b	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
ficate has be r, page 2 sho	Completed								24a. Was auto perfo 1 □ Yes		prior to c	topsy findings available ompletion of cause of		
this certi al directo	To Be	25. Was case referrexaminer? 1 Yes 2	No		tient 2 ☐ ER			4 LI Nursing Ho	ome 5 💢 Resi	idence	6 ☐ Other (Spec	sify)		
s after deam.	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined determined determined								28f. Location (n (Street and Number or Rural Route Number, Town, State)				
he Funer pletely fill	Medical	29a. Certifier (Check only one)	1⊠ Certifying P 2∐ Medical Exa	hysician: To the bes miner: On the basis and manner:	of examination	edge, deat a and/or in	n occurred at the ti vestigation, in my o	me, date and place pinion, death occur	, and due to the rred at the time,	cause(, date ar	(s) and manner as nd place, and due	stated. to the cause(s)		
O+	Σ	29b. Signature and		no-	-w			e number 3417			ate signed (Month			
123		Jame	s R. Moe	completed cause of n, M.D.,	,			ay, LaVal	le, MD	215	502			
Sta Registra		FEB 0		deneral 32. Regis	trar's Signature	المعاشين								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10+ nes 10-00868 Maury Silverman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Crivial yland / Department of Treath and Wentar T	, ,	g. No.						
Physici		Decedent's Name (First, Middle, Last)	2. Date of Deat Month		3. Time of Death					
Medical Exami	ner	Mauly Morton Silverman	January 30	0, 2010	1423 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	h	4c. County of Death						
		Washington Advenist Hospital Takoma Park	lo n	Montgomery						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hn Months Days Hours Mir		h(MM/DD/YYYY) 9. Birt Foreign	ashington					
Bilector		Usual Residence of Decedent								
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
* .	_	MD Montgomery Takoma Park			1 X Yes 2 No					
daryland 28a-f show	왕	10e. Street and Number 10f. Zip Code	10	ng. Citizen of What Cour	try?					
the M a or 2 tified	Director	7206 Flower Avenue #2 20912		U.S.A						
r death with the Maryland or items 23a or 28a-f sho must be notified at once,	əral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Americ						
death or ite	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o Ricari, etc.)	White, etc.	ite					
s after rral", niner	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	and a decay	ореспу.						
2 hour "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business/li	idustry					
336 thin 7 than than	ng l	4 Researcher		Holistic	Health					
215-0036 be filed within 72 hours after death with the Maryland nnal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N							
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be		ice Mill							
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ore, MD es 1 and 2 sho of Health and If item 27 is her traumati		Miriam Komisarof/Sister 16 Rolling Road Wynne 20a Method of Disposition 20b. Place of Disposition (Name of cemetery.	ewood, P.	A 19096	Town State					
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		The crematory or other place)	/2010	Washington						
Baltimo permit. Page Department c Important: injury or ott	- 1	4 Donation 5 Other Specify: Cemetery								
Balt Barti Departi Importi injury	-	21. Signature of Funeral Service Licensee Kurt Blake M01477 22. Name and Address of Sasitisky-1170 Rockville Pil								
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval					
/Medical	- 1	failure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease			Between Onset and Death					
Examiner		or condition resulting in death) Due to (or as a consequence of):								
	<u>,</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	miner	Chisease or injury that initiated								
sit ed	Exal	events resulting in death) Last Due to (or as a consequence of):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d. UNPENDED AMENDED								
60, ate be hysicia e buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery						
587 ertifica ling pl		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant	ancy		ay Year					
OX (Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)		1						
the de ched	튄	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to t	he cause of death?					
, P.O. res that th signed by be detach	<u>5</u>		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown					
ords, w requir s been s should b	ompleted		24a. Was a		opsy findings available					
e law e has ge 2 sh	d E		autops perform 1 V Yes 2	med? death?	ompletion of cause of					
Vital Rec ysician: The his certificate director, page	ပိ	25. Was case referred to medical 26 Place of Death (Check	الشا	No 1 Yes	2 No					
Vita hysicia this cer	8	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursin	ng Home 5 I	Residence 6 Other:						
ding Phy After tl	<u> </u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred						
ion ttendi death.	랿	1 V Natural 5 Pending 2 Accident Investigation								
ivis for A after Direc	ertification:	3 Suicide 6 Could not be determined (Specify)	28f. Location (S or Town, St	treet and Number or Rur ate)	al Route Number, City					
ospita hours neral	O	4 Homicide		<u> </u>						
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) One descripting Physician. To the best of my knowledge, death occurred at the time, date and place, and								
To To com	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)					
4		my his no		January 31, 2010						
	ł	30. Name and address of person who completed cause of death (Item 23a)								
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
	ate									
Regist	Tel.	TED OF TOTAL PROPERTY								

			1 - State of Maryland / D		rtment of Hea tificate of Dea			ienez ()	10	05216
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death		2Ŏ°11′0	3. Time of Death 6:20 A M
	/Medic	al	Helen Kathaline Spielman 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death	repruar		y of Death	0.20 A "
	Examin	er	212 S. Westside Avenue		Funkstown				hingt	on
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) (rs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Sep 16,	^{Year)} 1912	9. Birthp Cour Mar	place (State or Foreign try) yland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Lor	cation				1	0d. Inside City Limits
the Marylan 28a-f show		tor	Maryland Washington Funks	st.a	wn					1√2Yes 2□No
th the	or 28	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of		ntry?
	eath w	Funeral	212 S. Westside Avenue 11 Marital Status 12. Was Decedent Ever in U.S.	12 \	21734	nic Origin? (Spe	ocify Vas or No-	U.S.A	ce - Americ	ean Indian
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be multiled at once.	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Hispar fYes, specify Cuban, M □Yes 2 ☑ No Sp	lexican, Puerto	Rican, etc.)		ack, White, o	
	72 hou natura ical E	eted	(Specify only highest grade completed)	(Give i	lent's Usual Occupation kind of work done during	n ng most of worki		16b. Kind of E		
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2	i filed I Hygid other rent, tr	Be Co	17. Father's Name (First, Middle, Last)	<u>ou</u>		Mother's Name	(First, Middle, N			
3	ould be Menta arked atic ev	To B	George Shanklin Rosenberg			Alice J	ane Jaco	bs		
3	12 sho h and 7 is mi rraumi				g Address (Street and I					
5	tem 2				Whitehall sition (Name of patory or other place)			20c. Location		
	Pages nent of int: If it				Cemetery	02/15	/2010	Funkst	own,	Maryland
	permit. Departn Importa any inju		21. Signature of Funeral Service License	22	Name and Address of	Facility Bas	t-Stauff	er Fur	eral	
			23a. Part 1. Ever the disease, or complications in caused the fleath. Do no shoot, or heart failure. List only one call each line.		er the mode of dying, su	uch as cardiac o	or respiratory arr			Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition resulting in death)	lus	we &	isse	all			Onset and Death
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	p .:	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the hat initiated events c.	of):						1
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5	ate be executed hysician and the burial-transit	dical E	Suc to (in as a consequence of	.,.						
			U							
5	The law requires that the death certific tate has been signed by the attending page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)				ate of delive lonth	ery Day Year
	uires that the de signed by the a d be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in	the un	nderlying cause given in	Part I.		es 2 12 No	ntribute to t	he cause of death?
5	w requires t s been signe s should be	Completed	Porte Esentiment of	Re	Ix less	eese	24a. Was a		. Were auto	opsy findings available
	Physician: The lar this certificate has ral director, page 2)OIII	X		,		autops perforr	ey ned? 2 ☑ No	or to co death? 1 ☐ Yes	mpletion of cause of 2 □ No
3	iclan: sertific ector,	Be (25. Was case referred to medical examiner?			. Place of Death	(Check only on	e)		
5	Attending Physician: redeath. ector: After this certifica by the funeral director, p	 12	1	<u> </u>			me 5 Areside 28d. Describe ho			fy)
5	nding ath. r: Afte e fune	ation		njury	28c. Injury at Work? M 1 □ Yes	2 □No		,,		
-	al or Atte safter des l Director d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, stre	eet, factory, office		28f. Location <i>(Si</i> City or Towl		nber or Rura	al Route Number,
1	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.							
	To the complete compl	Me	29b. Signature and title of certifier SHMUE Chav, m.)		29c. License nui	mber	7	Ped. Date sign	ed (Month,	Day, Year)
5 1	1-12		30. Name and address of person who completed cause of death (Item 23a) (*324 EAST ANTIETAM SINUP.	Туре,	ville 200.	HAGE	estow.	N/M	021	740
	Sta Registr		31. Date filed (Month, Day, Year) September 12 2010 32. Registrar's Signature	1	E. U.S					
	negistr	aı	FED 12 2010 Serve B.	4	ave					

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registra MEND(023a(b))perMD, 2/2/10, BW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Stephen Ward Schumacher 01/28/2010 8:15A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 5500 Friendship Blvd. Apt. N1722 Chevy Chase If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days New York Hours 1⊠M 2□F 10/26/1940 69 579-54-5952 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examiner's ust be notified at 1 ☐ Yes 2 No Chevy Chase Director Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ö United States 20815 5500 Friendship Blvd. Apt. N1722 23a Funeral items ? 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 6 Specify: White 1 ☐ Yes 2 ☑ No ş 3 Widowed 4 Divorced than "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Messenger permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other t any injury or other traumatic event, 11 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Marjorie Olive Ward Frederick Albert Schumacher ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth L. Schumacher / Spouse 5500 Friendship Blvd. N1722 Chevy Chase, MD 20185 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/30/2010 Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner death certificate be executed and burial-tran Due to (or as a consequence of): physician Box 68760, Physician/Medical the as I IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 □ Pregnant at time of death 9 □ Unknown 5 ☐ Other (specify) Ö ed by the a detached f ۵. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate I 1 ☐Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Hon-Yeun Wong

31. Date filed (Month, Day, Year) FEB 02

30. Name and address of person who

MD

02

Rockville Pike #13A Rockville, MD 20852 751 32/Registrar's Signature

ompleted cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00t3260

29d. Date signed (Month, Day, Year)

January 29, 2010

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY Alasan Samateh 201 Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death BALT (MORE Examiner 4c. County of Death SINAL MOSPITAL OF BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Hours 51 Director 188-62-8938 /5/1958 Bakau Gambia Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland **Funeral Director** Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2912 East Northern Parkway 21214 Gambia 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiers Important: If item 27 is marked other than any injury or other traumatic event, the Meoone. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care <u>Director of</u> Ultimate Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kassama Samateh Mama Drammeh AT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Fatoumatta M. Samateh-wife 2912 East Northern Pkwy Baltimore, Md.21214 A B 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Banjul, Gambia Family Cemetery 2/7/10 permit. Signature of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary 411 Kennedy St. NW Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final MULTIPLE CUA Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MYOCARPIAL INFARCTION ACUTE Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) 1 Yes 2 No 9 Unknown been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 1 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate Yes 2 X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕅 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗆 No X Natural 5 Pending Accident Suicide Homicide Investigation Director: 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) RES -000 Acus Shaema MBBS 29,2010 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

1 X Yes 2 No

20011

Approximate Interval Between Onset and Death

DC

Dav

4: 15 PM

DHMH 17 Rev 7/2009

State Registrar W Belvedere

2401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 20b per F.D. 02/05/2010 Carroll Co. will

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ${\tt P}^{\,{\sf M}}$ **Physician** 2:00 1, 2010 <u>Janet Marie Stewart</u> February /Medical 4c. County of Death a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 71 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, **Funeral** Days 1 □ M 2√□ F 219-34-2615 Feb. 8, 1938 MD Director Usual Residence of Decedent the Maryland 10d. Inside City Limits oc. City, Town or Location Manchester 10b. County 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If "Medical Examination and be notified at Carroll MD 1 ⊈Yes 2 🗌 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21102 3048 Westminster St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: 3 Midowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11 college (1-4or 5+) Child Care Provider Child Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Marie Miller John W. Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 115 North Allwood Dr., Hanover, PA 17331 Gary Massicot - Son 20b. Place of Disposition (Name of Pleasant Valley Cem. 2/8/2010 20c. Location - City or Town, State 20a. Method of Disposition $\frac{-2/6/2010}{}$ Westminster, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 21. Signature of Juneral Service Lic 412 Washington Rd., Westminster, MD 21157 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1/23/10 to2/2/1 **Physician** Choxic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STE Sequentially list conditions, if any, leading to turning dial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo fue às a consecuence offi law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No P.O. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 4No 2 🕡 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WIL 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W6Stylluster ,45 21157 10106et 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Februar Lake Russell Slacum 2010 02 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner Genera orches Hospitai dare orchester ambn 8. Date of Birth (Month, Day, June 2, If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year **Funeral** Months Days Hours 1**⊠** M 2□ F 220-32-2229 72 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at MID Dorchester 1 XYes 2 □ No Director Cambridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 4 Oueen Anne Avenue 21613 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. ģ Specify: white 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry in and 2 should be filed within if Health and Mental Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) district manager electric company 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lake Russell Slacum Elena Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Julie P. Slacum 4 Oueen Anne Avenue, Cambridge, MD 21613 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State Old Trinity Churchyard 2/4/10 Church Creek, MD 4 Donation 5 Dother (Specify) aure of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovaleder **Physician** Arteriosclardhe /Medical Due to (or as a consequence of): Examiner Ischemic Due to (or as a consequence of) Examine that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE nse yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No the 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No-Physiclan: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **I**No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔐 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

Records,

Division of Vital

State Registrar 29b. Signature and title of certifier

NOMAN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed can

Vatana

se of death (Item 23a) (Type, Print) BYRN

503

32. Registrar's Signature

29c. License number

CAMBRIDGE

29d. Date signed (Month, Day, Year)

2-2-10

70 21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Teresa Marie Trossbach 2010 February 4:45 a.m Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>43029 St. John's Road</u> Hollywood St. Mary's Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland Hours 1 | M 2 | X | F 10/14/1923 Director 220-24-8083 86 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No <u>Maryland</u> St. Mary's Hollywood 10f. Zip Code 10g. Citizen of What Country? Funeral 43029 St. John's Road 20636 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian ģ Yes 2 No Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matthew Clarence Aud Estelle. Agnes Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Trossbach/Daughter 43029 St. John's Rd., Hollywood, MD 20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, Charles Memorial Gr. 02/06/2010 Leonardtown, MD 4 Donation 5 Other (Specify) Signama Funeral Serice Action Research R. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Jr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ obstructive Chronic Mulmonary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner egus maran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed? Yes 2 No in 24 hours after death.

The Funeral Director: After this certificate hapleted filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗓 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0055682 attendin 30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Thomas M.

31. Date filed (Month, Day, Year)

Wilkinson

<u>FERU 4 2010</u>

M.D.

Registrar's Signatur

32.

23140 Moakley Street, Leonardtown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 0045 AM burcz 2 2010 /Medical 4a. Facility Name (Il not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Nursing Center Calvert Prince Frederick 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours 015-01-5682 Director 94 07/04/1915 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Hem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Middian Examination to notified at 1 ☐ Yes 2 No Directo Maryland Calvert Solomons 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13325 Dowell Road 20688 United States Was Deceas.
Armed Forces?

Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 2 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominic Spinazola မ Julia Yunllie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie O'Brien/Daughter 16475 Harms Way, Piney Point, MD 20674 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department of Important: If any injury or once. injury or 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Brinsfield-Echols Cre 02/03/2010 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Spina disease or condition resulting in death) /Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2. No 2 No of Vital 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Choi,

Chang Bae

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

100 Hospital Road, Prince Frederick, MD

D0061783

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Ruth Elizabeth Taylor Physician/ February 1 2010 Year 10:35 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Morningside House of Laurel P.G. Laurel 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 Months Days Hours Min och 22ay, Year 17 191-09-8501 92 PA **Director** Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 y No Montgomery Silver Spring 5 10e. Street and Number 10g. Citizen of What Country? items 23a 1604 Dennis Avenue 20902 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: Specify: Completed 3X Widowed 4 ☐ Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Walter Jackson Steed Mary Iva Cameron .f. Page 1 and 2 shou...

t of Health and Mer

"" Sim?" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therese T. Sammartino/Daughter 1604 Dennis Avenue, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 X Removal from State Feb. 4, St. Thomas Catholic Church Bedford, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses ²²Francis Addres Colimbias Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Alzheimer's Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Sacral Decubitus, Osteoporosis, Hypertension Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No 2 X No ☐ Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 2 😾 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Living 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work?
1 \(\sum \) Yes 2 \(\sum \) No injury X Natura 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) D53235 Feb. 3, 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB

arked

o completed cause of death (Item 23a) (Type, Print) 13635 Baltimore Avenue, Laurel, MD 20707

32 Registrar's Signatur

war

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Leila Rosella TAYLOR 2010 4:15 February a. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Williamsport Retirement Village Washington Williamsport 8. Date of Birth
(Month, Day, Year)
March 4,1923 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 🕱 F Hours Pennsylvania Director 217-18-7949 86 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland rector Washington 1 X Yes 2 No Maryland Maryland Williamsport ā 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ō Examiner must be 23a Funeral 21795 USA 154 Artizan Street or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 No Specify. white and Mental Hygiene.

is marked other than "natural", Specify: 3 x Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) timekeeper aircraft mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley Earl Stine Leila Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a David W. Taylor - son 17326 Virginia Avenue, Hagerstown, Md. 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Greenlawn Mem. Park 2/11/10 Williamsport, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME <u>21</u>740 Ε. Wilson Blvd., Hagerstown, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final LATERAL SCLETZOSIS Physician/ 4MYOTROPHIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending p for use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death yes 2 □ No ed by the a g 🗌 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Records, Completed 1 Tes 2. No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has b I director, page 2 sh autopsy performe death? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 🔀 No ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

C74-5 State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOME N 31. Date filed (Month

2010

WILLIAMS PORT ARTICAN ST

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	f Marylar	nd / Depa	artmen	t of H	lealth	and N	lental Hy	/giene	9	1.0	0 =	
			State Registrar			Cer	tificate	e of D	eath			Reg. No	<u>. 20</u>	1 U	05	122
	Physicia	an/	Decedent's Name (First, Middle, La.	st)							Date of De Month		31/	Year	3. Time	of Death
Janea,	Medi	cal	Evelyn	Ruth	Tyr	pak	1				Januar	y 2		010	5:08	3 A. M
	Examir	ıer	4a. Facility Name (if not institution, give		oer)				Location of			40	. County o	f Death		
μ-4	r'	7	18 Lloydminster 5. Social Security Number 6. S		7 A == //=	(Ga:		rsbur If Under				Mont	gome		
	Funeral Director			M 2 🛣 F	7. Age (In yrs. i	16 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept.	th y, Year	022	9. Birthpl	ace (State y) esota	or Foreign
		1	Usual Residence of Decedent			0					Sept.	9, 1	923	Minn	esota	
	and sho	ē	10a. State 10b. County		10c. Cit	ty, Town or Loc	cation							10	d. Inside (City Limits
	Mary 28a-f	Director	Maryland Montgo	merv	G	aither	sburg								1 🗆 Ye	s 2 🛣 No
	the a or 2	٥	10e. Street and Number				10f. Zip					10g. Ci	tizen of W	nat Count	ry?	
	s 23; nust	Funeral	18 Lloydminster	Court			20	878			- 1	Ţ	Jnite	d Sta	ates	
	death item ner n		11. Marital Status	12. Was Deced			Vas Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race	- America	n Indian,	
36	after I", or camii	l by	1 Never Married 2 Married	1 ☐ Yes If Yes, Give	2 X No		Yes 2				nearl, etc.,			White, e	tc.	
Ş	ours atura	Completed	3 X Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dat	es.								Specify:	Wh	ite	
Ϋ́ Ü	72 h n "ng Aedio	du	(Specify only highest gr			16a. Deced	ind of wor	k done di	tion <i>uring most</i>	of worki	ng	16b. K	(ind of Bus	iness Indi	ustry	
72	/ithin iene. r tha	ŝ	Elementary/Seconday (0-12)	College (1-4	l or 5+)	I .	o <i>noruse</i> Secre	,				Fad	eral	Corre	rnmar	· †
b	lled v I Hyg othe	Be	17. Father's Name (First, Middle, Last)			<u> </u>	CCIC		18. Mothe	er's Name	(First, Middle,			0000	I TIME I	
a	d be f fenta rked tic ev	욘	Rudolf	Finand	er						Hilda		eters	on		
Maryland 21215-0036	hould and N s ma		19a. Informant's Name/Relationship (7			19b. Mailin	g Address	(Street ar	nd Numbe		Route Numbe				nde)	
Σ	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, retem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Julie Olson/Daugh	nter							Gaithe					20878
ore.	of He of He fiten		20a. Method of Disposition			Place of Dispos	sition (Nam	e of			ate		ocation - C			
Ĕ	Page 1 ament of Faunt: If its		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		iuio	remetery, crem	-			/29/	2010	Δ1 م	xandr	rt a	Virai	nia
Baltimore,	permit. Page Department Important: I any injury o	1	21. Signature of Funeral Service Licens	see 1	11						ol Fund				VILGI	IIIa
m	8 2 E 8 8		Melice	SIL	elex	/					r., Gai				20	877
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that ca	used the death	h. Do not enter	r the mode	of dying,	, such as o	cardiac o	respiratory an	rest,			Approxima Interval Bel	te
-	hysician/		Immediate Cause (Final disease or condition			Heart	Fad 111	ro						1.	Onset and Week	Death
	Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	14114								week	5
		7	Sequentially list conditions,	D		rdial	Infar	ctio	n					6	Week	S
	oit d	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	ience of):										
	ecute and I-trans	xar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to for	as a consequ	ience of):										
	be ex sician burial	gal	Toolaning in dodain, Edot	230 10 (0.	20 4 00110040	iorioc cij.										
9	icate be executed physician and s the burial-transit	edical		d												
BOX 68	certifi nding use a:	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco									00-1 D-1-	- 4 - II - II		
õ	eath a atte	icia	in the past 12 months? 1 ☐ Yes 2 🔀 No	4 🗌 Pregna	nt at time of d	Ideath 3 ☐ leath 5 ☐	Ectopic pr Other (spe					1	23d. Date Month			Year
	the d	hys	g 🗌 Unknown	g 🗌 Unkno												
7. Ö	s that gned e det	by F	Part II. Other significant conditions co	ontributing to dea	th but not resu	ulting in the un	derlying ca	ause giver	n in Part I.		23e. Did to	bacco u	se contribu	ite to the	cause of d	eath?
as,	quires en siç suld b		Hypertension								1 🗆 1	Yes 2	XI No 3	☐ Proba	bly 4 🗌	Unknown
Ö	aw re as be 2 sho	ble									24a. Was a		24b. We	re autops	y findings a	available
ě	The Istantia	Completed									autop perfor	rmed?	dea	th? Yes 2		ause or
Vital Records,	ctor,		25. Was case referred to medical examiner?					26. Plac	e of Death	ı (Check ı		2 22 110				
>	hysic this c	၉	ILI res 2 LA NO			ER/Outpatient	3 🗆 DO	Other:	4 🗌 Nur	sing Hom	ne 5 🔀 Resid	ence 6	Other (Specify)		
0	After funer	Certificate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	injury <i>Day, Year)</i>	28b. Time of injury		c. Injury a work?		- 1	3d. Describe h	ow injury	occurred			
2	death death tor: / the / the	<u>∰</u>	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		lui ac All		М		es 2 🗆 N	-						
DIVISION OF	after Direc	Š	4 ☐ Homicide determined	building,	etc. (Specify)	me, farm, stree	et, factory,	office		2	8f. Location (S City or Tow		Number o	r Rural R	oute Numb	er,
	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Phys	ician: To the best	t of mv knowle	edge, death on	cured at th	ne time d	ate and o	lace and	due to the con-	ise(s) and	d mannor o	is stated		- (
:	n 24 h	Ned	(Check 2 Medical Examinonly one) 3 Certifying Nurs	ner: On the basis (of examination	and/or investig	ation, in m	v apinion	death occ	urred at t	ne time date ar	and place	and due to	the course	e(s) and ma	nner stated.
1	Vithi To the Comp	— г	29b. Signature and title of certifier	0/11/1		A . AT		_icense n		- Id place			e signed (A			
	D		MANUVAGAA	YMM	111	M		D 38	3589				uary			
	-	ļ	30. Name and address of person who co	ompleted cause of	of death Wem	23a) (Type, Pri	nt))ر بر	,,,,,,			Juli	uu y		-010	
			Jonathan Plotsky,				ove I	Raod	, Roc	kvil	le, Man	ryla	nd 20	850		
	State Registra		FEB 0 2 2010	32. Regi	strar's Signatu	are face	1									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#23eperMD2/5/\$toatenni/Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2010 6:25p M Louis Taub January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6111 Montrose Road. Montaomeru Rockville #211 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Country) Poland 1 🛛 M 2 🗆 F Days Hours Min. (Month, Day, Ye Mau 09 90 Director 060-28-7050 Usual Residence of Decedent shov 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🗓 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A 6111 Montrose Road, #211 ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 X Widowed 4 Divorced Caucasian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than 'n other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Shoemaker Manukacturing Be Yisrael Turteltaub 18 Mother's Name (First, Middle, Maiden Surname) Ette Malka Hagoz — Unknown 17. Father's Name (First, Middle, Last) - Visrael Truteltaub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malka Kutnick - Daughter 11106 Stillwater Avenue, Kensington, MD 20895 Baltimore, 20b. Place of Disposition (Name of Landfill Campatory of other place)
Landfill Campatory of other place)
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or otl once, 1 X Burial 2 Cremation 3 X Removal from State 01/29/2010 Monticello. New York 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses DWC 111800 New Hampshire_Ave.. Silver Spring. MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ischemic Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Scumbly it anditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) death certificate be executed burial-transit <u> Aortic Stenosis</u> Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Mitral Regurgitation Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4- Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy page performe certificate Yes 2 X No 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA |2 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 X Natural 5 Pendina within 24 hours after death. To the Funeral Director: A: completed filled in by the fu 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 101 Muri a. Deachale 29, 00041311 2010 JAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive M.D., Suite #200. Bethesda, MD 20817 6410 Rockledge Drice, Yuri Anthony Deychak, 31. Date filed (Ma Registrar's Signat State Registrar

10-00593	
Joseph Triolo	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oseph I riolo		State of Maryland / Departr 1-For State Certifi Registrar	ment of H licate of D			2010 ag. No.	05227
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)			Date of Deat Month	h Dav Year	3. Time of Death 1634 hrs
neuicai Exami	ner	Joseph John Triolo 4a. Facility Name (if not institution, give street and number)	4b. (City, Town, or Location	January 26 of Death	0, 2010 4c. County of Death	
		115 Ponytail Lane	Т	aneytown		Carroll	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	_	f Under 1 Year If Und Months Days Hour	s Min	th(MM/DD/YYYY) 9. Bin Foreig Co	thplace (State or In Penna untry)
ά		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov	wn or Location				10d. Inside City Limits
Maryland 28a-f show any <u>d at once.</u>	۲	Maryland Carroll		Tane	ytown		1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 115 Ponytail Lane	10	of. Zip Code		og. Citizen of What Cour	ntry? SA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, s	specify Cuban, Mexican		White, etc.	can Indian, Black, ite
rs after ural",	ð	Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16.		s 2 No specify.		Specify: 16b. Kind of Business/I	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of	of working life. DO NOT mematician		Applied Physic	,
21215-0036 Juid be filed within 7 Mental Hygiene. marked other than ic event, the Medica	S	17. Father's Name (First, Middle, Last)			r's Name (First, Middle, N	faiden Surname)	
1218 I be fill ental H arked	Be	Joseph Francis Triolo			Rita Schill:		
D 2's should and Mula is martice	٩	19a. Informant's Name/Relationship (Type, Print) Thomas Triolo, brother		•	mber or Rural Route Num , Narberth,		Zip Code)
e, MD and 2 sho lealth and item 27 is traumati	-2	20a. Method of Disposition 20b. Place	e of Disposition	(Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite			oll Cre	matory	1/29/2010	Winfield	, MD
Balt permit. Departi Import		2 Fignature of Funeral Service Licensee		and Address of Facilit E Baltimore	y Myers-Durk e St, Taneyt	oraw Funera	al Home 787
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.					Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic Cardiovasc Due to (or as a consequence of):	cular Diseas	se			Death
		Sequentially list conditions, b					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts resulting in death). Last					
60, tte be executed hysician and e bunal - transit		events resulting in death) Last Due to (or as a consequence or):					
O, e be exe rsician burial -	ledical	UNPENDED					
Sox 687(leath certifica e attending pl	-21	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal d	eath 3 Ectopio	c pregnancy	23d. Date of delivery Month D	day Year
P.O. Ess that the canada by the detached	by Pt	Part II. Other significant conditions contributing to death but not result	ting in the under	rlying cause given in Pa	334	bacco use contribute to t	
ords, P w requires t is been sign should be	ted				1 Yes		ably 4 V Unknown topsy findings available
of Vital Records, ig Physician: The law requirement that the this certificate has been so	Completed				autops	prior to comed? death?	ompletion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical		26.Place of Death		No 1 Ye	s 2 No
Vita sysician this cer	o Be	examiner?	/Outpatient 3	DOA Other		Residence 6 🗸 Other	Scene
ion of tending Ph. eath. or: After t	tion: T	1 V Natural 5 Pending (Month, Day,Year)	b. Time of Injury	28c. Injury at Work	_	ow injury occurred	
Division pital or Attendicours after death.	ertification:	3 Suicide 6 Could not be determined (Specify)	, farm, street, fa	ctory, office building, el	tc. 28f. Location (S or Town, St	treet and Number or Rur ate)	al Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated					
MIL	ž	29b. Signature and title of certifier		29c. License number O.C.M.E.		January 28, 2010	
19-		30. Name and address of person who completed cause of death (Item 23a Russell Alexander MD. Assistant Medical Examine	*	nn Street, Baltimo	ore, MD 21201		
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 9 2010 Leneus B	. Son	es .	A.C.:		
DHMH 17 Rev 1/20			RIGINAL			te.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryla State of Maryla Registra 2/5/2010 AACO HEALTH DEPT. OWN Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 29 2010 Allen Turner Jr. 10:35р м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 408 Merryman Road Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 12 XM 2 - F u IV I4 Year) 921 Marwiand Director 88 Yrs. <u> 215-16-9124</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyres 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Merryman Road 21401 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1944 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 21X Married 1 ☐ Yes 2 XNo Specify: B1ack Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within remeth and Mental Hygiene.
27 is marked other than "remeir event, the Mer (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4th <u>Motor Vehicle Operator</u> US Naval Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Allen Turner Sr. Pearl Johnson traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Doris Turner (Wife) 408 Merryman Rd. Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 2/5/10 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resses& Jeen MOOY8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ rovascul disease or condition resulting in death) must Medical Due to (or as a consequence of): Examiner Langer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or all a consequence of): ng physician and as the burial-transit death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 L 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ e 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certitying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[In the description of 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in the opening of the date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert S, Fiben medical Prive 2002

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year ам Gilman Vaughan Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HCR-ManorCare Momtgomery Chevy Chase Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 227**-**28-7510 1 □**M** 2 □ F Months Days Hours Min. Country) 80 Director 0/20/29 Virginia Usual Residence of Decedent artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shor 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits DC Washington 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7413 9th Street 20019 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 **X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Professional Driver Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eiva Anna Clayde Lee Ashland f and 2 should be the Health and Me 19a. Informant's Name/Relationship (Type, Print) / Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Permelia Carvella Beavers 3215 Park View Rd. Chevy Chase, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Lincoln Memorial 2/5/10 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ CORONARY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2-No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes Other: 2-1NO 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to apprete of filled in by the funeral 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ew, MD 00057124 213/10

Registrar

State

9715 Medical Center Dr. Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatul

Truong Bao, MD

31. Date filed (Month, Pay, Year)
FEB 0 5

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AA CO Health Dept 2-17-10 KAH 1 - State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vinores Month FCh num 00 45 George 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) 87 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV • 25, 1922 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours 194-12-5152 Pennsylvania Director Nov. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Arnold 1 Tes 2 X No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 616 Oakland Hills Drive, Apt 101 21012 USA 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2

No If Yes, Give WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural" 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 4 Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matthew Vinoris Francis Ambrose Vainoris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Vinores / Son 278 Meridian Street Apt. 11 Groton, CT 06340 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory, INC. Baltimore, MD 2010 of Funeral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Interval Between Myocardial Immediate Cause (Final Onset and Death Physician/ Dro hable disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the attending physician and ched for use as the burial-transit executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day 9 Unknown P.0. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) niner? 1 X Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident 5 \square Pending Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining in regarding in the desir of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my showledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 30641 (1ante 2010 epnial 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lever negl Jabapalki 201-109 1STCK 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 05 2010 Registrar

Amend #17 per FH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month White 2010 РМ Russe11 5:25 Wayne 27 January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 17740 Maxwell Hall Place Hughesville Charles 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) February 24,1946 Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Min Days Hours 231-58-3389 63 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Charles Hughesville 1 □Yes 🏹 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17740 Maxwell Hall Place 20637 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Master Plumber Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laverne Alexander White Edna L. Dawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Anne White/Wife 17740 Maxwell Hall Place, Hughesville, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) 29, 2010 Charlotte Hall, MD Signature of Funeral Service Lie 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., ¬ MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No robably 4 🗌 Unknown 24a. Was an autopsy performe 1 □Yes 2 24b. Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experime must be restified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It. M. M.

72 hours after death with

Baltimore, Maryland 21215-0036

burial-transit and physician the as attending signed to be deta has page certificate

law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Hospital or Attending Physician:

Examine Physician/Medical Completed Be this Medical Certification: To funeral After t in 24 hours area.

the Funeral Director: Afternately filled in by the funeral filled in the funeral filled in by the funeral f

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of De th

29a. Certifier (Check only

1 Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 Suicide 4 ☐ Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Prince) 31. Date filed (Month, Day,

32. Regist ar's Signature 0 2010

State Registrar

within 2.

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Physician /Medical Examiner The law requires that the death certificate be executed

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. once.

Physician

/Medical

10a. State

Examiner

Funeral

Director

r 28a-f show notified at

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heath and Mental Hygiene. of them 27 is marked other than "natural", or items 23a or 28a-f show

altimore, Maryland 21215-0036

7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

Examiner burial-tran Medical attending for use as signed by the certificate has b irector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical nours after death.

neral Director: A
filled in by the fu

Division or Vital Records, P.O. Box 68760,

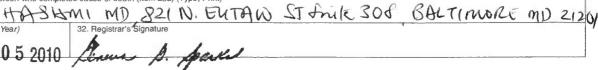
l yaiciaii/ii	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 ⊟Ectopio	pregnancy (specify)		23d. Date of delivery Month Day Year
בת הא בו	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	g cause given in Part I.		acco use contribute to the cause of death? s 2 No 3 Probably 4 Mo nknown
Toll Indian					24a. Was an autopsy perform 1 Yes 2	prior to completion of cause of
0	25. Was case referred to medical			26. Place of Dea	th (Check only one	9)
2	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Adrising H	lome 5 Reside	nce 6 Other (Specify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	ŀ	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred
	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)
- Incar		nysician: To the best of my kno niner: On the basis of examina and manner stated.				ause(s) and manner as stated. ate and place, and due to the cause(s)
É	29b. Signature and title of certifier	0		29c. License number	29	9d. Date signed (Month, Day, Year)

D31464

State Registrar

A 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



(M)

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Walker Carol Jean 12:12 February 7.2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Boonsboro Reeders Memorial Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sep 3, 1938 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 □ M 2 □ X F Pennsylvania 207-30-2459 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 □ No Boonsboro Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21713 141 South Main Street 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married 1 □Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Freda Ethel Hopkins Fred Ι. Rish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Columbine Dr. P.O. Box 173 Keedysville, MD 21756 David W. Walker / Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/13/2010 |Keedysville, Maryland Fairview Cemetery 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Juneral Service License 7606 Old National Pike Boonsboro, MD 21713 Part 1 Enter the disease, r comshow, or heart failure. List only ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final allen disease or condition resulting in death) min Due to (y s a consequence of): Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ Ño 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 □Yes 2 ☑No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

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Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "notal Event her must be notified at once.

Maryland 21215-0036

Baltimore,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ng physician and as the burial-tran

Division of Vital Records, P.O. Box 68760,

Physician/Medical IF FEMALE <u>م</u> Completed Be Medical Certification: To 27. Manner of Death 1 Natural 2 Accident filled in by the 3 Suicide 4 Homicide 29a. Certifier completely

05H6-3

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet
31. Date filed (Month, Day, Year)
FEB 0 9 2010

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be determined

21 Wyand Drive Keedysville, MD 21756 EB 0 9 2010

28a. Date of Injury (Month, Day, Year)

and manner stated.

32. Registrar's Signatur

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

03251

1 ☐ Yes 2 ☐ No

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All	egany C	0.4	For Ame	end Ite	State o ms 23aPt	of Mary	dand 25, 2	/ Depa 7 , 28a	rtmen	t of H	lealth a e , g 90	nd Me	03/20	riene Fodh	b201	0	05234
			Registrar 1. Decedent's Name			,		Cert	ilicate	5 OI L) Call I		2, Date of De	ath			3. Time of Death
1	Physicia Medic	al	Jean	14	· Will	lian	25						Month 62	O Da		ar O	2100M
	Examin	er	4a. Facility Name (if I		give street and num Regional Med		enter		4b. City,	Town, or	Location of Cumb			40	. County of [Allegan		
	Funeral		5. Social Security Nu	ımber	6. Sex 1 ☐ M 2 🛣 F	7. Age (In		· · · ·	If Under	1 Year Days	If Under 2		3. Date of Bir (Month, Da	v. Year)	g.		ce (State or Foreign
	Director		214-36-66 Usual Residence of I		7 - 111 - 241		72	Yrs.					Octobe	ér 10,	1937	Магу	
	yland -f shov ed at	ctor	10a. State	10b. County		10	•	own or Loca	ation							10d	. Inside City Limits
	he Mai or 28a e notifi	Director	Maryland 10e. Street and Num	bor	egany	. (1)	Fros	tburg	10f. Zip	Code				10a. Ci	tizen of Wha	t Country	1 X Yes 2 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		3 MI	ount Pleasant	Sueer			21	1532-				U.S			
'	er death or item niner n	by Fu	11. Marital Status 1 Never Marrie	ed 2 Marr	12. Was Dece	edent Ever orces? 2 X No	in U.S.	13. W	as Deced Yes, spec	lent of Hi ify Cuba	ispanic Origi n, Mexican,	in? (Specii Puerto Ri	fy Yes or No- can, etc.)		14. Race - A Black, V	American Vhite, etc	
3036	urs afte ural", o Il Exan	d par	3 Widowed 4		If Yes, Giv Year or D	ve '		1	☐ Yes	2 X No	Specify:				Specify:	White	:
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212	within giene. er tha t, the N		Elementary/Seco	onday (0-12)	College (1	I-4 or 5+)		teache		reureaj				ed	ucation		
Maryland 21215-0036	should be filed within 7 hand Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (F		ast)							r's Name (i i beth E	First, Middle,	Maiden	Surname)		
ary	nould the lind Me s mark		19a. informant's Na		nip (Type, Print)		1	19b. Mailing	Address	(Street a			Route Numbe	er, City or	r Town, State	e, Zip Cod	de)
	nd 2 slealth a m 27 i		Billy Lon		son			10911 V			ad	Fros	tburg		Maryla	ınd	21532-
Baltimore,	age 1 a int of H t: If ite / or otl		20a. Method of Disp 1 Burial 2	Cremation	3 Removal from	n State	ceme	e of Disposi etery, crema	atory or o	ther plac		Da			ocation - Cit		
altin	mit. Pa partme portan / injun		4 ☐ Donation 21. Signature of Fun				FIC	ostburg 1			ss of Facility		y 12, 2010	FI	ostburg	1015	aryland
m	permir Depar Impor any in		Joh	n R	Wurst	-		Ü	Durst	Fune	ral Hom	e, 57 F	rost Ave	., Fro	stburg, N	MD 21	532
	Ministration of		23a. Part 1. Enter the shock, or hear Immediate Cause (F	t failure. List c	nly one cause on ea	ach line.										ln:	pproximate iterval Between inset and Death
	mysician/ ► Medical		disease or condition resulting in death)		a. Due to	(or as a co	nsequenc	ce of):	co	rdi	-(I	nfar	ction			P	ays
7	Examiner	<u>.</u>	Sequentially list cor	nditions,	bC	ORO	nov	y 8	rte	ny	Dis	ung					Hores
	red nsit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	lying injury	Due to	(or as a co	i iSequei i	ce of):		/					L EXAMINER		
	executed an and irial-transit	I Exa	that initiated events resulting in death) L		C. Due to	(or as a co	nsequenc	ce of):			CERT	TIFICATION	APPROVED 8	< Kitenio		\top	
09/	ate be physici the bu	edica			d							Out			-	+	
Box 68760	certific inding I use as	Physician/Medical	IF FEMALE: 23b. Was decedent		23c. If yes, ou	tcome of p	regnancy	, eath 3 🔲	5.1						23d. Date o	f delivery	
Box	death the atte	/sicia	in the past 12 n 1 ☐ Yes 2 🗗 9 ☐ Unknown		4 Preg	gnant at tim	ne of deat	th 5 🗆	Other (sp	pecify)	;y 				Month	Da	ay Year
$\mathcal{I}_{\mathcal{E}} \ \bowtie \ \mathcal{E}$ Division of Vital Records, P.O.	that the led by t	by Phy	Part II. Other signifi	icant condition	ons contributing to c	death but n	ot resultir	ng in the un	derlying o	cause giv	ven in Part I.		23e. Did t	obacco	use contribu	te to the	cause of death?
ds, l	quires ten signant	ted b	Chur	mic	obstrui	iv	Pr	lmor	Lusa	•	n'sen	ET	1 🗆	Yes 2	□ No 3[Probab	oly 4 Mnknown
cor	law re has be le 2 sho	Completed	Tra	dur	Rig	1-7-+	tip.	•					24a. Was	psy	prio	r to comp	findings available findings available for findings available
E Re	in: The ificate or, pag		25. Was case referre		Fracture					26 PI:	ace of Death	(Check o		2 N	1 _	Yes 2	□ No
Vita	hysicie his cert Il direct	To Be	examiner? 1 A Yes -2					/Outpatient	3 🗆 DO	Loui	er:		e 5 🗆 Resi	dence (6 ☐ Other (S	Specify)	
n of	ding P th. After t funera	cate:	27. Manner of Death Natural 2 Accident	5 Pendir	28a. Date 02/0	of injury 1th, Pay, Ye 2/201	ear) 28 O 11	b. Time of injury Inknow	1	8c. Injury work 1 🗆	?	- 1	d. Describe I Subjec		•		
r E	er deal rector: by the	Certificate:	3 Suicide 4 Homicide	Investiq 6	not be 28e. Place		At home	, farm, stree		_	-					r Rural Ro	oute Number,
Dis.	oital or ours aft eral Die	Sal		-	Hom	e											oute Number, Pleasant
25	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical ((Check 2	☐ Medical E	Physician: To the baxaminer: On the ba	sis of exam	ination an	nd/or investig	gation, in a	my opinic	on, death occ	curred at th	e time, date a	and place	e, and due to	the cause	(s) and manner stated.
1			29b. Signature and t	title of certifier		-					number				ate signed (M		
1	8		30. Name and addre	ess of person	who completed cau	se Of death	ı (Item 22	a) (Type Pr	int)	W 2	2124 STBU	4		2	18/2		
	mes		Jesus :	TAN	41	SROF1	dh	AY	1	ROS	STBU	19	m	9	215	32	
	Sta Registr		31. Date filed (Month	9 2010	agree 32. F	Registrar's	Signature	we									

Amended Part II, nls,

			1 - For State of Maryland / Dep	artment of Health and Nertificate of Death	, ,	ene . No.	03230
	· ·		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Nancy Wolford		February	3, 2010	12:50 A ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
-			The Casey House	Rockville		Montgomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign ntry)
	Director		245-66-3202 66		July 4, 1	.943 New	York
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary f sh	ļo	VD V1				1 ¥ Yes 2 □ No
	r 28a	irec	MD Montgomery Brooke	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	3a o	E D	3324 Richwood Lane	20833		U.S.A.	
	death	ner		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
9	or ite	by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	nican, etc.)	Black, White,	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evantrat rust be redthed at	d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	**			White
5-	"nati	Completed	15. Decedent's Education 16a. Deci (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/Ir	ndustry
12	withir sne.	E D	Elementary/Secondary (0-12) College (1-4or 5+)				
	filed within Hygiene. other than "		17. Father's Name (First, Middle, Last)	ologist 18. Mother's Name	e (First, Middle, Ma	Researc iden Surname)	1
an	d be ental ced o	To Be	Harry Kanzer	San	ah Zern		
Maryland	should be f and Mental s marked o' umatic eve	F		ing Address (Street and Number or Rui		City or Town, State, Zi	p Code)
	nd 2 alth a 27 Is 27 Is		1	324 Richwood Lane			
re,	item item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of	Date 20	c. Location - City or T	own, State
E	Pages nent of hant: If ite		1½ Burial 2 □ Cremation 3 □ Removal from State Satisfies, of Church C	mattery Feb	9, 2010 E	Brookeville	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Importament of Heath and Mental Hygiene. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Evaluter or ust be rediffed at any injury or other traumatic.		21. Signature of Funeral Service Licensee M01597	2. Name and Address Dangans	ky-Goldbe	rg Memoria	al Chapel
Δ_	89789		Melissa Greenhut 1	170 Rockville PIke	, Rockvil	le, Maryla	and 20852 110
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Metastatic Breas		or respiratory arres	t,	Approximate Interval Between Onset and Death
j	/Medical		resulting in death) Due to (or as a consequence of):	c odnocz			
	Examiner	L	Sequentially list conditions, b.				
h	ted isit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury				
ν	and al-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				<u> </u>
8760,	cate be executed obysician and the burial-transit						
687	ificate g phy- is the	edic	0.				
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical		□ Ectopic pregnancy		23d. Date of delive Month	very Day Year
P.0	ires that the de signed by the be detached	hys	9 ☐ Unknown				
S, F	ss tha gned	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	w require s been si should t				1 ☐ Yes	2 No 3 Pro	bably 4 🔀 Unknown
Vital Records,	ne law re e has be ge 2 sho	Completed	•		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
ā	sician: The certificate h rector, page		25. Was case referred to medical	00 81 (8	1 □ Yes 2 X		2 K No
>	Physician: r this certifica ral director, p	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othory	h (Check only one)	ce 6 XOther (Spec	Hospice
of	ing Phys n. After this funeral dir	Ë	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how		у повртсе
jo	ath. nr: Aff	atio	2 Accident investigation	M 1 ☐Yes 2 ☐No			
Division	l or Atte after de Directo J in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.				
	Vithir Vomp	Me	29b. Signature and title of certifier T. Kouckhou, MD	29c. License number	29d	. Date signed (Month	Day, Year)
	12		J. Koudschell, 1115	163748	Fe	bruary 3,	2010
	•		30. Name and address of person who completed cause of death (Item 23a) (Type		tchou, MD		
			201 East University Parkway, Baltimo	ore, Maryland 2121	8		
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) 2. Registrar's Signature 2. Registrar's Signature 2. According to the signature 2. According	N. J			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2010 ear FeBnth 18:03 M Physician/ 4 Beverly Kagan Wachtel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Bethesda</u> Montgomery <u>Suburban Hospital</u> If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Days Hours February 12 Year 931 1 M 2 F Washington DC 579-24-5692 78 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5225 Pooks Hill Road #209S 20814 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3

Widowed 4 □ Divorced Year or Dates marked other than "natur 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clothing Store 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental 1 and 2 should be fill f Health and Mental item 27 is marked other traumatic ev ည Bertha Blank Herschel Katz 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other troonce. 4330 Cartwright Way, North Potomac, Maryland 20878 Marc Zitelman/ Son in Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State King David Mem. Grds 2/12/2010 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee A Greenhut 22. Name and Address of anizansky-Goldberg Memorial Chapel Manhor 1170 Rockville PIke, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
8 Days Immediate Cause (Final Ph sician/ <u>Intracranial Hemorrhage</u> disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cerebral Vascular Accident 1 Day Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit 2 Days Myocardial Infarction that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Years Coronary Artery Disease LE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 2 😾 No been signed by the same should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hypertension 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia autopsy performed? or Attending Physician: The 2 ty No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 K Natural 5 Pending thin 24 hours after death.

the Funeral Director: Aft
empleted filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my onlines, death occurred at the cause(s) and manner as stated. Hospital Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my knowledge. within 2

To the I

complete nly on 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 Do0 55612 10 February 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Morton, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814

Registrar

31. Date filed (Month, Day, Year)

FEB 09 2010

Registrar's Sign

	1123 ibeth K. Wa	tson	Ple	ease Ty	pe or Print i	n Bla	Depai	d elil	ble Ink.	Ensur	re All Co	opies A	Are Le	gible	20i0	05237
			1- For State Ame	#1(nd #4a	ate of Maryla 0,2/16/201	0.Pe	er Cen	PR	te of Be	eath	ia incinc	ar r rygr	R	eg. No.		
24	Physicia	an/	Decedent's Nam	e (First, Midd	le,Last)							2. [Date of Dea Month	Day	Year	3. Time of Death 1259 hrs
iviec	lical Exami ∖	ner	Elizabe		Watson on, give street and no	ımber)			4b. C	ty, Town, o	r Location of		ebruary		O County of Deatl	
	,				ed 2405	Rut	hbu	Š	Rd. Ce						ueen Anne's	
	Funeral		5. Social Security N		6. Sex	7. Age	Urg. I	st birth		Under 1 Ye	_	24Hrs. 8. Min.			DD/YYYY) 9. Bir Foreig	n
	Director		218-30-4		1 M 2 XF		77		Yrs.				08/02	2/19	32 6	untry) NY
)	any		10a. State	10b, County		- 1	10c. City,	Town	or Location							10d. Inside City Limits
	eath with the Maryland items 23a or 28a-f show ust be notified at once.	اق	MD	Queen	e <u>n</u> Anne '	s		Cent	trevil				- 14	On Citie	zen of What Cou	1 Yes 2 No
	e Mary or 28a- ied at	Director	10e. Street and Nu		- Da-3				101.	Zip Code	7				ted Stat	
	with th	_ L	2405 Rut 11. Marital Status	cnsbur	12. Was De		Ever in U.S	š.		cedent of H	ispanic Origin		y Yes or No		14. Race - Amer	ican Indian, Black,
	death '	Funera	1 Never Marri		larried Armed F	2[X No		If Yes, sp	pecify Cuba	in, Mexican, F	Puerto Rica	an, etc.)		White, etc.	
	s after rral", miner	<u>آھ</u>	3 Widowed		vorced If Yes, Give Ye or Dates: ecify only highest gra		nleted)	16a D		2k No	o s <i>pecify:</i> ation (Give kir	nd of work	done		Specify: WI'	lite
	72 hour	Completed	Elementary/Sec								e. DO NOT us		30110	100.7	and of Basiness.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	5-0036 led within 7 Hygiene. other than the Medica	du	12						Offic	e Mana				<u> </u>	Medical	
	filed v filed v if Hygi ed oth	Be Co	17. Father's Name Harold I								18.Mother's Sarah				Surname)	
	Ore, MD 21215-0036 ps 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she ther traumatic event, the Medical Examiner must be notified at once	To B	19a. Informant's Na					19b.	Mailing Add	ress (Stre					ty or Town, State	e, Zip Code)
	ore, MD es 1 and 2 sho of Health and If item 27 is her traumati				- daughter	:	0.01 . 0								MD 216	
	2 5 5 E 5		20a. Method of Dis		n 3 Removal f	rom Sta	te CI	remato	f Disposition ory or other pl	ace)			'2010			
	Baltimo permit. Page Department o Important: Injury or oth		4 Donation 5			MO		ck (Creek (ET A				shingtor	
	Balti permit. Departur Importu		Ca. J	Val	-	MO	1411		4112	old (r :Columb	наггу ia Рі	rн. w ke El	lic	ke's Fam Ott City	ily F.H.Inc
	Physician		23a. Part I. Enter the failure. List or		r complications that of on each line.	aused	the death.	Do not	enter the mo	de of dying	, such as car	diac or res	piratory arr	est, sho	ck, or heart	Approximate Interval Between Onset and
	/Medical Examiner		Immediate Cause or condition resulti		Due to (or as	ng	comp1	ica	ated by	y hypo	ertens:	ive a	thero	sc1	erotic	Death
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		iner	if any, leading to in cause. Enter Under	erlying Cause	Due to (or as	a conse	quence of)):								·
	ecuted and transit	Examine	(Disease or injury events resulting in		Due to (or as	a conse	quence of)):								
		dical	XUNPENDED)	AMENDED	23a	.PTT.	27.	.28a-f	per l	ME g900	0 2/2	4/10	TT		
	Box 68760, e death certificate be extitle attending physician ed for use as the burial		IF FEMALE: 23b. Was decedent	pregnant in t	23c. If yes,	outcom		ancy	Fetal de			oregnancy		230	. Date of deliver Month	y Day Year
	x 68 th certificate the certif	iciar	past 12 month		4 Preg		time of dea	ath 5	=		Cotopie	oreginality.			1001101	34,
	D. Box 1 the death o by the atten ached for us	Phys	Part II Other sign		tions contributing t		but not re	sultina	in the under	lving cause	given in Part	I.	23e. Did to	obacco	use contribute to	the cause of death?
	Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be detached for u	d by		re disc	_					,			1 Ye	s 2 🗸	No 3 Pro	oably 4 Unknown
	rds requires	Completed		-									24a, Was autop			itopsy findings available completion of cause of
	Record The law	mo											perfo 1 Y Yes	rmed? 2 No	death?	es 2 No
	ician: certifi rector.	Be (25. Was case reference examiner?	rred to medica	Hospital:	Inpatie	nt 2	EB/O	itpatient 3	26.Plac	Other	Check only Nursing He		Pasida	nce 6 🗸 Othe	r Scene
	of Vital Records, ng Physician: The law require the configuration of t	. To	1 Yes 27. Manner of Dea	th No	28a. Date	of Inju	y T		ime of Injury		ury at Work?					hot tub
	ion tendin eath.	ation	1 Natural 2 X Accident		ding a	h, Day,Yi		Fd	12:59	pm ¹□	Yes 2 X	No 30	Бјесс		owned in	
	Division tal or Attendi us after death. al Director: A	Certification:	3 Suicide	6 Cou	ald not be ermined (Specify		ury-Atho resid			ctory, office	building, etc.					iral Route Number, City IS BUTG Rd
3	Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director. page 2 should be deat	cal Ce	4 Homicide 29a. Certifier (Check only one)	Certifying F	hysician: To the beaminer: On the basis	st of my	knowleda	e. dea	th occurred a	t the time,	date and place	e, and due	to the caus	se(s) an	ville, Modernment of the state	ed.
	Toth withi Toth comp	Medical	29b. Signature and	1	aparmanner	stated			ga.ion, I		nse number		_,		Date signed (Mo	
			1	1/						O.C	.M.E.			Feb	ruary 8, 201)
3	OCME		30. Name and add		n who completed cau Deputy Chief				111 Pe	nn Stree	et, Baltimo	re, MD 2	21201			
	S	tate	31. Date filed (Mor			egistrai	's Signatu		Loan							
	Regis	trar		LFDT	0 2010 /	line	1	fil a	March							

Physician. Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

shov

or 28a-f

items 23a

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'natural",

and Mental Hygiene.

permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve

traumatic event, the Me ical Examiner must be notified at

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner burial-transit and

attending physician for use as the burial use as the signed by the a page 2 s has After this certificate director, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral c

Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

		Due to (or as a consequence of):	
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):	
dical Exa	Cause (Usease or firing y that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.	
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Completed by PI		ive Pulmonary Disease, ory Failure	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ♣☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available
Comp			autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Be	25. Was case referred to medical examiner?	26. Place of Death (Check of	only one)
မ	1 ☐ Yes 2 🙀 No		e 5 Residence 6 Other (Specify)
ficate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) Injury work? M 1 Yes 2 No	d. Describe how injury occurred
Medical Certificate:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)
Medica	(Check 2 Medical Exami	ician: To the best of my knowledge, death occured at the time, date and place, and ner: On the basis of examination and/or investigation, in my opinion, death occurred at the e Practioner: To the best of my knowledge, death occurred at the time, date and place,	ne time, date and place, and due to the cause(s) and manner stated

MD Drive, Olney, MD 20832

29c. License number

D35045

29d. Date signed (Month, Day, Year) February 5, 2010

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (MFEB) 09 2010

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma		artment of Heal		ental Hygie	ne No 2 0 1 0	05239
	_		Registrar 1. Decedent's Name (First, Middle, Last)	<i>Ce</i>	ertificate of Dea		Reg. 2. Date of Death	No.Z. U I U	3. Time of Death
	Physici		William Roger Zepp				Month	Day Year 31, 2010	11:30 p M
- 3	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death	Julian	4c. County of Dea	ıth
-			106 N. Center Street 5. Social Security Number 6. Sex 7. Age	/la cas la at historia	Westmi		0. Date of Pieth	Carı	
H	Funeral Director		218–32–6831 1 M 2 □ F	(In yrs. last birthday 75 Yrs.		ours Min.	8. Date of Birth (Month, Day, Ye Aug 5, 15	ar) C	rthplace (State or Foreign ountry) Tyland
	put w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla -f sho	ţō	Maryland Carroll	roo. Oily, fown of E		tminste	er		1 XYes 2 □ No
	or 28a)irec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What C	ountry?
	s 23a	Funeral Director	106 N. Center Street			21157		USA	
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The "Action Ever; here, instituted once.	/ Fune	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 1 □ Never Married 2 Married 1 □ Never Married 2 Married	1055	Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 ☑ No Sp	nic Origin? (Spe exican, Puerto F ec <i>ify:</i>	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	hours ntural",	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education		edent's Usual Occupation		166	. Kind of Business	
215	thin 72 e. an "na Modio	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	e kind of work done during DO NOT use retired)	g most of workin	g	Grocery S	
121	led wil Hygien her th nt, the	S	12	Me	at Cutter	Madha da Nama	(First, Middle, Maid		Score
land	ald be findental herical heric	To Be	17. Father's Name (First, Middle, Last) George A. Zepp				C. Welch	gen Surname)	
Baltimore, Maryland	d 2 shouth and h		19a. Informant's Name/Relationship (Type. Print) Barbara A. Zepp, wife		ing Address (Street and N N. Center St				
ore,	as 1 an of Heal fitem 2 r other		20a. Method of Disposition		osition (Name of ematory or other place)	Da	ate 200	c. Location - City or	
Ē.	t. Page tment tant: II		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Carrol	1 Crematory	02/02		Winfield	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee		22. Name and Address of I 91 Willis St		vers-Durb Vestminst	oraw Fune er, MD 2	eral Home 1157
		1	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not er	nter the mode of dying, such	ch as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician /Medical				ic Latera	al Sch	erdis		3 months
	Examiner		Due to (or as a	consequence of):					
	p ti	iner	Sequentially list conditions, it any leading to him ediate cause. Enter Underlying Cause (Disease or injury	a consecreture of).					
	execute and al-trans	Examiner	that initiated events	a consequence of):					
58760,	ficate be executed physician and s the burial-transit	edical	d						
99	ertifica ling ph e as th	Medi	IF FEMALE:					1	
Вох	death certific e attending p d for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	elivery Day Year
P. O.	0 0 0	hysic	1 Yes 2 No 9 Unknown 9 Unknown	time of death 3					
ds, I	law requires that the dias been signed by the 2 should be detached	δ	Part II. Other significant conditions contributing to death bu	t not resulting in the ι	underlying cause given in I	Part I.		co use contribute t 2 ☐ No 3 ☐ F	o the cause of death? Probably 4 🗹 Unknown
Records,	s been shoul	olete					24a. Was an		utopsy findings available
<u> </u>	The ate h	Completed					autopsy performed 1 Tes 2	prior to !? death?	completion of cause of
Vital	ysician: The iis certificate director, pag	å	25. Was case referred medical examiner? Hospital: Hospital:		Othor		(Check only one)		
ō	or Attending Physician: fiter death. Director: After this certific, in by the funeral director,	<u>ا:</u> 1	27. Manue of D. th 28a. Date of Injur	nt 2 ER/Outpatie	of 28c. Injury at		ne 5 Residence 8d. Describe how i		ecify)
ioi	Attending death.	atio	1 atural 5 Pending (Month, Day, investigation	(Year) Injury	M 1 ☐ Yes	2 No			
Division of	lor Att after de Direct	Certification:	Guicide 6 Could not be determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, st . <i>(Specify)</i>	reet, factory, office	2	8f. Location (Stree City or Town, S	t and Number or F tate)	lural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of Medical Examiner: On the basis of and manner state.	examination and/or in	th occurred at the time, dancestigation, in my opinion	ate and place, a	and due to the caused at the time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)
	To the within 2 To the Comple	Med	29b. Signature and title of certifier	ted.	29c. License num	nber	29d.	Date signed (Mon	th, Day, Year)
	~ W		BALCONN		10.37	1501	6	311120	010
ري	MOL,		30. Name and white of personal his completely of use of del	ath (Item 23a) (Type,	102. Si	ita	200	Hank	Pick
	Sta		31. Date filed (Month, Day, Year) 32. Registra	r's Signature	10 Mc., 01	111t	3,00	ur	710
	Registra	ar	FEB 0 2 2010 Comm	~ B. A	are			-1	60716°

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 1808P 2010 DEBORAH ADDISON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 7. Age (In yrs. last birthday) 52 vre If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yo 216-76--1788 1 □ M 2 🛛 F Months Days Hours Min. WASHINGTON, DC Director 1957 Usual Residence of Decedent 28a-f shov 10a, State 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director MD MONTGOMERY SILVER SPRING Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 13211 BLUHILL RD 20906 U.S.A. ritems 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black, White, etc. 1 Never Married 2 Married ò þ 1 Yes 2X No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" 3 🗌 Widowed 4 🗎 Divorced Completed BLACK Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE HOMEMAKER 11thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GRAPHTON COPELAND MARY ELIZABETH WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GILMORE ADDISON/HUSBAND 2 RUSSELL AVENUE SILVER SPRING, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GATE OF HEAVEN 2-27-2010 SILVER SPRING, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician ASCVD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s or Attending Physician: The law has autopsy performed' certificate 1 ☐ Yes 2 X No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🔀 No 1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ျှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director: /
completed filled in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital the

> State Registrar

only one)

29b. Signature a

3

d title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN GRUFFERMAN, MD 1500 FOREST GLEN RD SILVER SPRING, MD 20906 32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

2.4.2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D24348

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a or

Items

Hygiene. other than "natural", or I

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other than any Injury or other traumatic event.

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

ည

MD

event, the Medical Examiner must be notified

burial-trar attending physician for use as the buria Division of Vital Records, P.O. Box 68760 page

Hospital or Attending

funeral director. After this 24 hours after death. Funeral Director: A filled in by the

Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by MELOFIBROSIS 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 18,2010

D0057450

Registrar

completely

within 2 To the F the

31. Date filed (Month, Day, Year) FEB 24 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IVANA GOJO; 22 SOUTH GREENE STREET, BAUTHORE, MD 21201 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-		1 - State Registrar	State of Maryland		rtificate of		•	Reg. No.	2010	05242
	Physicia	an	1. Decedent's Name (First, Middle, Las	#) Welen Catherine	Raer			2. Date of De Month Februa	ath Day	Year	3. Time of Death 5:55am M
	/Medic Examin		4a. Facility Name (If not institution, give		- Daei	4b. City, Town, or	Location of Death			1, 2010 County of Death) :33aii
	Lxaiiiii	eı	Lorien Nursing &				. Airy			Carı	
	Funeral Director		217 22 0005	ex 7. Age (In yrs. k	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov . 27	th Year)	9. Birthp Coul	place (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mary Ind	tor	MD Carro	11		Eldersbu	rg				1 ∐Yes 2 ∭XNo
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
	23a c	ral	1653 Brimfield C	ircle		217					USA
	er deg	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1 Types 2 Types	3. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No o Rican, etc.))- 1	 Race - Americ Black, White, 	
036	should be filed within 72 hours after death with the Maryland rund Mentalle Hygiene. In Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umarked other than "natural".	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2∏No	Specify:			Specify:	White
Baltimore, Maryland 21215-0036	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		dent's Usual Occup		kina	16b. Kir	nd of Business/In	dustry
121	vithin ane. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	oo not use retired omemaker	1)	9	_ n	omo sá á -	
2	filed v Hygie nther t	ပ္ပ	17. Father's Name (First, Middle, Last))11	лиешакег	18. Mother's Nam	ne (First, Middle		omestic	
an	ld be fental ked o	To Be	Walter Conl	ev				Marsh		ŕ	
ar	shou and N s mai	_	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street			er, City or	Town, State, Zip	Code)
Σ.	and 2 ealth n 27 i		Ms. Joan Marie Ba			Brimfiel				•	
0	ges 1 nt of H If itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		sition (Name of natory or other place		Date		cation - City or To	
	it. Pa irtmer irtant: injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licens			Cremati				esville,	, MD
Вa	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Licens	Budt Man	7/4 17	AIGHT FUN D Box 195	ERAL HOMI	E & CHAP	PEL,	P.A.	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death						4	Approximate Interval Between
in the second	Physician	1	Immediate Cause (Final disease or condition	Pneumonia	l					d	Onset and Death 1 day
1	/Medical		resulting in death)	Due to (or as a consequ	ence of):						
	Examiner	<u>_</u>	Sequentially list conditions,	b. Due to (or as a consequ	ongo of:						
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unions of Industrial and the state of the stat	Due to (or as a consequ	ence ory.						
) O	exection and and rial-tra		that initiated events resulting in death) Last	C Due to (or as a consequ	ence of):						
68760,	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical		,d							
Š ×	ertific ding p	/Med	IF FEMALE:	000 16 100 0140000 06 010000						l	
ROX	eath cer attendir for use	sian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnanc Other (specify)	у		2	3d. Date of deliv Month	ery Day Year
		nysid	1 □Yes 2 □XNo 9 □ Unknown	9 Unknown	Jan 3 L						
ດຸ 7.	requires that the veen signed by th hould be detache	by P	Part II. Other significant conditions co	ontributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did 1	tobacco us	se contribute to t	he cause of death?
Records,	equire sen siç ould b							1 🗆	Yes 2	No 3☐ Prol	bably X Unknown
ပ္မ	law r has be	Completed						24a. Was auto	psy	prior to co	opsy findings available of
<u>a</u>	ding Physician: The law h. After this certificate has funeral director, page 2 !							1 □ Yes	ormed? 2 XINo	death? 1 □ Yes	2 💢 No
VItal	slclar certif	Be c	25. Was case referred to medical examiner?	Hospital:	ED/O	Oth	26. Place of Dea				
0	g Phy er this eral d	n: T	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ I 28a. Date of Injury	28b. Time of	f 28c. Injur	yat	ome 5 ☐ Resi 28d. Describe		☐Other (Speci.	fy)
DIVISION	al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, ps	Certification:	Natural 5 ☐ Pending 2 ☐ Accident investigation		injury	M 1 🗆	<br Yes 2 □ No				
≦ ≥	or Atte ter de irecto	rific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To	Street and wn, State)	d Number or Run	al Route Number,
2	pltal o		On Continue 4VI Continue Bloom	To the beat of	1-41-4-4						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A completely filled in by the fo	Medical	29a. Certifier (Check only one) 1 Certifying Physical Example (Check only one)	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my o	ppinion, death occu	rred at the time,	date and	place, and due t	o the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
			I had a		mo	D005	9423		Feb	ruary 2	2, 2010
	5		30. Name and address of person who								MD04.5.5.
	Sta	ie.	31. Date filed (Month, Day, Year)	1.D. 11165 Stra 32. Registrar's Signat	ure		Ist flo	or, Marı	riott	sville,	MD21104
	Registr		FER 24 2010	General S. 4	bores	,					
	4H 17 Dou 1/0	204									

DHMH 17 Rev 1/2001

		For State Registrar	State of	Marylan		artment of tificate of		and M	ental Hy	giene Reg. No	2010	05243
Physicia		1. Decedent's Name (First, Middle	, Last)		B	rown			2. Date of De	eath ,Da	ay Year	3. Time of Death
/Medic		4a. Facility Name (If not institution		oer) ·		4b. City, Town			reprud		2/, 20/0 c. County of Death N/A	
-	-	The Johns Hopkins 5. Social Security Number	•	7. Age (In yrs. I	ast birthday)	Baltimo		24 Hrs.	8. Date of Bir	rth		place (State or Foreign
Funeral Director		212-44-1224	1 X □M 2□F	61	Yrs.	Months Day		Min.	2/27/	48 48	MD	ntry)
yland how		Usual Residence of Decedent 10a. State 10b. County MD N/A		10c. City	y, Town or Lo	cation						10d. Inside City Limits
the Mar 28a-f s	Director	MD N/A 10e. Street and Number		bai	CIMOI	10f. Zip-Code			1	10a Cit	tizen of What Cou	1 X Yes 2 □ No
23a or	ral Di	2041 E. Bidd	lle St.			2121	3			ÜS	tizen of What Cou A	muy:
OO36	d by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 X Divorced	12. Was Deced Armed Ford 1 Tes If Yes, Give Year or Date	ces? 2. X No	'	Vas Decedent of Yes, specify Cu	ıban, Mexicar	n, Puerto R	cify Yes or No ican, etc.))-	14. Race - Ameri Black, White, Africal Specify: Amer:	etc.
: 2	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1 2		or 5+)	(Give	lent's Usual Occ kind of work dor DO NOT use reti rk Lif	ne during mos red)	st of workin	g		ind of Business/li instruct	,
Maryland 212- d 2 should be filed within lith and Mental Hygiene. 27 is marked other than reaumatic event, the Ma	To Be C	17. Father's Name (First, Middle, L Alfred Ford					18. Moth Jun	er's Name Le Ca	(First, Middle bines	e, Maidei SS	n Surname)	
e, Mary t and 2 sho Health and I tem 27 is me other trauma		19a. Informant's Name/Relationsh Tonia Brown/I	ip (Type. Print) Daughter		19b. Mailir 2041	g Address (Stre E. Bi	et and Numb ddle	st.,	Balt.	per, City MD	or Town, State, Zing 21 21 3	o Code)
Baltimore, cermit. Pages 1 a Department of He Important: If item any Injury or othe once.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other Se			emetery, cren ZiC	sition (Name of natory or other p on Cem.	1	2/27		Bal	ocation - City or To	
Baltimo		21. Signature of Fulleral Service L	e-								266-5	YS5 ^{PA}
Physician		23a. Part 1. Enjer the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on eac	used the death h line. Sent	1		ying, such as Che			arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Duè to (o	r as a consequ	uence of):							
sit ad	Examiner	Sequentially list conditions, want, leading to manufacture cause. Enter Underlying Cause (Disease or injury	Due to (a	r as a nonsequ	iance ofy:							
8760, cate be executed physician and s the burial-transit		resulting in death) Last	cDue to (o	r as a consequ	uence of):							
8760, icate be ex physician as the buria	edical		d									
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Vital Residen: The language 2	Be	25. Was case referred to medical examiner?	Hospital: V.				ther:		Check only o			
on of aling Physi n. After this of funeral directions.	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig:	28a. Date of (Month,		ER/Outpatient 28b. Time of Injury	28c. In	4 🗆 Nu	28	e 5 🗌 Resid 3d. Describe		6 ☐ Other (Special Iry occurred	5y)
Divisi	ertification:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place o	f injury - At hor , etc. (Specify)		et, factory, office			3f. Location (City or Tox		nd Number or Rui ?)	al Route Number,
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To the confidence of the confi	ž	29b. Signature and title of certifier	7			_	nse number	or			ate signed (Month,	
	-	30. Name and address of person v	who completed cause	of death (Item	23a) (Type. I		0	20		reor	wary, 21,	2010
		Brian M. Than 31. Date filed (Month, Day, Year)	41					600 N	orth Wo	lfe S	t, Baltimo	re, MD, 21287
State Registra	~	FEB 2 4	2010	istrar's Signatu	1. fa	well						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Wilbert Buechling Year Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street Examiner rescent Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 2 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shov Even instrougt be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 207 panic Origin? (Specify Yes or No-Mexican, Puerto Rican, etc.) Was Decedent Ever in Armed Forces? 1 Yes 2 Tho If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of H If Yes, specify Cuba Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █ No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Madical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4or 5+) UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be INKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TO., MD 21202 Jan. 2 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SKARDA 23a. Part 1. Enter the disease, of complications that caused the deam. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANDIOVASCULAR DHERTE fattaio Schenoric **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ubstructure Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Nemote Cerebral autopsy performed 2 🗆 No 2 🗐 🗓 1 ☐ Yes Dementia Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1. Natural 1 ☐Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 ☐ Homicide To the Hospital c within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 4203 QUEENSbury Rd Hyattswille MD 2078 VORF 32. Registrar's Signature 31. Date filed (Month, Day, Year) State LED TO

Registrar

10-01527 James Ball Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nes Ball	1	Sta For State	ate of M	aryland		rtment of <i>tificate of</i>			Menta	al Hyg		No	2011	0 0	5245
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તાંcal Examine	r,	James	E.		E	Ball		Sr.			Month February 2)	0241 h	rs
	4	ta. Facility Name (if not institutio	n, give street	and numbe	er)	4	b. City, To Baltimo		cation of I	Death			ounty of Death		
	٩,	University Hospital 5. Social Security Number	6. Sex	17 A	Age (In yrs. la	ıst birthdav)	If Under		If Under:	24Hrs.	8. Date of Bir		/////) 9. Birl		e or
Funeral Director							Months		Hours	Min.	01/07		Foreig		
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ath wit	nera	11. Marital Status 1 X Never Married 2 M		rmed Force		S. 13. Was	es, specify	Cuban, I	Mexican, F	Puerto Ri	ican, etc.)		White, etc.	out main, a	
ter de:	1		orced If Yes,	Give Year	2 X No	1	Yes 2	X No	specify:			Sp	ecify: Bla	ck	
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6 72 hc	<u>e</u>	Elementary/Secondary (0-12)	C	ollege (1-4 o	or 5+)	3		•					rth Ar		
5-0036 iled within 7 Hygiene. I other than	Completed	47 Canada Nama (Cina Middle		<u>Year</u>		Sec	<u>urit</u>	y Of	fice Mother's	er_	irst, Middle, I		genhut	: Seci	irity
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2121 buld be fi Mental I marked ic event,	라	19a. Informant's Name/Relations	hip (Type, P	rint)		19b. Mailing	Address	(Street	and Numb	er or Ru	ral Route Nur	nber, City	or Town, State	, Zip Code)	
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s l an of Hea If iten		20a. Method of Disposition 1 X Burial 2 Cremation	3 Re	moval from		Place of Dispos crematory or oth		e of ceme	etery,		Date	200. Loc	ation - City of	rown, state	
imo Page ment c		4 Donation 5 Other S	pecify:			ng Mem									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers in Programmers of Health and Mental Hygiers than "natural", or items 23a or 28a-f sho injury or other transmic event, the Medical Examiner must be notified at once	1	21. Signature of Funeral Service	Licensee	,), 0	Vinin	227	osepi	n H	Br	own	Jr. I	June	ral Ho imore	ome	1217
Physician	+	23a. Part I. Enter the disease, or	complication	ns that caus	sed the death.	. Do not enter the	ne mode of	dying, s	uch as car	rdiac or r	espiratory an	est, shock	, or heart	Approxim	ate Interval Onset and
/Medical	1	failure. List only one cause Immediate Cause (Final disease	8.4143		hot Woun	ıds									eath
Examiner		or condition resulting in death)			nsequence o										
	ا <u>ه</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a co	nsequence o	f):				·-				 	
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certificant	cian	past 12 months?	4	Live birth Pregnant	n t at time of de		tal death her (Spec	ify)		pregnan	Cy	, "		,	
Box 68760, he death certificate be the attending physic red for use as the burned for us	Physician/M	1 Yes 2 No 9 Ur	known 9												C death?
ें के के कि	B P	Part II. Other significant condi	tions contr	ibuting to de	eath but not r	esulting in the	underlying	cause gi	ven in Par	rt I.		_	e contribute to		Unknown
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aw rec	흺								_			ormed?	death?	completion o	_
Records, The law require ficate has been si	Completed							e Bloss	of Death (Chook or	1 Yes	2 No	1 🗸 Y	es 2	No
Vital I ysician: his certifi director,	Be	25. Was case referred to medic examiner?	al Hospita	al: 1 Inc	atient 2	ER/Outpatien			241			Residence	ce 6 Othe	er:	
of Viring Physic	ှိ	1 Yes 2 No 27. Manner of Death	2	8a. Date of	Injury	28b. Time of		8c. Injur	y at Work?		28d. Describe		occurred		
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Division of Vital tal or Attending Physician: rs after death. The Director: After this certiled in by the funeral director.	Certification: T	3 Suicide 6 Co	ald not be	28e. Place o	of Injury - At h	nome, farm, stre	et, factory,	office bu	uilding, etc	c. 2	28f. Location or Town,	(Street and State)	Number or Reet, Baltimo	ural Route N	umber, City
in spi	Cert	4 Momicide			Local Stre										
5 4 5 5	edical	29a. Certifier (Check only one) Certifying Certifying Medical Ex	Physician: Taminer: On t	o the best on the basis of the	of my knowled examination a	dge, death occu and/or investiga	rred at the ition, in my	time, da opinion,	te and pla death occ	ice, and o curred at	the time, date	use(s) and e and place	manner as sta e, and due to t	ned. he cause(s)	
To the I within 2 To the I complet	Med	29b. Signature and title of certif	and	manner stat	ted			. License					ate signed (M		ar)
		my hi		50				O.C.N	Л.E.			Febru	uary 20, 20	10	
		30. Name and address of person													
		Ling Li, MD Assist	ant Medic	100		1 Penn Stre	et, Baltir	more, I	MD 212	01					
Sta		31 Date filed (Month, Day, Year		32. Regi	strar's Signal	ture Land	2)								

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 10-01355 Vincent Bryan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cent Bryan		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2010 0524											
a Dhuabia		Registrar 1. Decedent's Name (First, Middle,Last)								of Death		3. Time of Death	
ా Physicia ্বে Exami	ner	Vincent Bryan								uary 1	Day Year 4, 2010	1315 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore											
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	_	If Under 2	Min		Fore	irthplace (State or eignJamaica	
Director		590-46-5267	1 X M 2 F		51 Yrs	Months	Days	Hours	Min. 8-	-12-		country)	
	ļ	Usual Residence of Decedent		140- 63	y. Town or Locat	-						10d. Inside City Limits	
w an		10a. State 10b. County			•							1 X Yes 2 No	
yland	흕	MD 10e. Street and Number	na	Ba	ltimor	e 10f. Zip 0	code			10	g. Citizen of What Co	ountry?	
e Mar or 28a	Director	5742 Cedonia Avenue Apt E				21206					Jamaica		
with the 18 23a		11. Marital Status	12. Was De	cedent Ever in	U.S. 13. Wa	s Decedent	of Hispa	anic Origin	? (Specify Ye	s or No-		erican Indian, Black,	
death r iten	Funeral	1 X Never Married 2 M	Forces? 2 X No	2 X No			s, specify Cuban, Mexican, Puerto Rican, etc.)				Dlagle		
after		3 Widowed 4 Div	1	Yes 2 X No specify:				10	Specify: BIGCK 16b. Kind of Business/Industry				
hours 'natu	fed					during most of working life. DO NOT use retire						i	
36 hin 72 c. than edical	Be Completed by					oorer				Phillips Foods Inc			
5-0036 lled within 7 Hygiene. I other than		17. Father's Name (First, Middle	, Last)		1 = 4.00		18				laiden Surname)		
121: be fill ental F urked vent.		Arthur Bry	an		100 14-35-	- 1	/Ch-= =4	Naon	ni Ne	lso	n her City or Town Str	ate, Zip Code(T3J486	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryland Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Examiner must be notified at once.	٢	19a. Informant's Name/Relations Cecil Bryan-			124 S	Saddl	e C	reek	Terr	E Ca.	lgarv Al	berta,Can	
and 2 sho fealth and tem 27 is		20a. Method of Disposition			o. Place of Dispo	sition (Name			Date	-	20c. Location - City		
ages l nt of H t: If i		1 Burial 2 Crematio	-	from State G	reenmon			2	2-27-2	010	Balto,	MD	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility								East F/H	i i		
Den Den		Sunto 16	yas								e Balto,	MD 21202 Approximate Interval	
Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause	e on each line.									Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)		leg ulcer	complicating	atheros	clerotic	c cardi	ovascular	diseas	<u>se</u>		
		Sequentially list conditions, b											
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
ed N	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
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Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. The Law to Founeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	<u>ج</u>	Part II. Other significant cond	itions contributing	to death but no	ot resulting in the	underlying	cause gr	ven in Par				Probably 4 Unknown	
ords, v require s been sig	eted								2	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of			
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tal Recian: The certificate ector, page	l o	25. Was case referred to medic	:al			2			Check only or	ne)			
Vita nysicia nysicia this ce	0 0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	✓ ER/Outpatier			Other ₄	Nursing Hom			ther:	
n of ding Pl	on: T	27. Manner of Death 1 Natural 5 Pe	(Mo	ate of Injury onth, Day, Year)	28b. Time of	Injury 2		yat Workî es 2		escribe	how injury occurred		
Division tal or Attendii rs after death. al Director: /	Certification:	Accident Pending Investigation 2 Accident 2 Accident 2 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2Bf. Location (Street and Number or F									Rural Route Number, City		
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the													
To th within To th	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
								February 15, 2	2010				
30. Name and address of person who completed cause of death (Item 23a)											1		
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
\$	state	31. Date filed (Month, Day Yea	3 4 2010 32	Registrar's Sig	nature	ark						01.15	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05247 for State Registrar Reg. No. Certificate of Death 1. Decedent's Name First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 19:40 1 Conary 2010 /Medical er Location of Death 4a. Facility Name (If not institution, give street and number) City, Town, 4c. County of Death Examiner Itimare 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F Director arolina Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 ☐ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country ò or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Yeo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ≥ Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) root 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cotton Eugene abeth ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Spouse ILN ulverst. eto eter wa 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State OWINGS MILLS - MI) 4 ☐ Donation / 6 ☐ Other (Specify) Torest 21. Signature Juneral S price Lice 22. Name and Address of Facility FredHILTON 23a. Party, E. 1. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, md. 21229 Approximate Interval Between Onset and Death Immediate Fause (Final **Physician** er Malemi O disease or condition resulting in death) /Medical or as, a consequence of) **Examiner** dilease Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be execute for use as the burial-trans PIYUTOr Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, aftending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 1 ☐ Yes 2 No 3 Probably 4 Unknown 7510N 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy prolomyo 2 No 1 □ Yes 1 ☐ Yes 20 No Il or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 patient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tyes 2 No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

timore

ar's Signature

21229

and address of person who completed cause of death (Item 23a) (Type, Print)

2010 ▶

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month MITTEL /Medical February 2010 05 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2X F Months Days 220-54-7177 Director 60 12-9-1949 Usual Residence of Decedent 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Yes 2 No na Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 519 N. Rose Street Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene, 21205 U S Α 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced 1 ☐ Yes 2 🔀 No Specify: 'natural" Year or Dates: Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Banquet Cook Sheraton Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Robert E. Woods Louise Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Tracey Booth-daughter 4523 Green Rose Lane Baltimore, MD 21213 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Crownsville Vet 4 Donation 5 Other (Specify) 2-26-2010 Crowsville, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility March East F/H -Milh 1101 E. North Avenue MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final **Physician** Onset and Death disease or condition resulting in death) Small cell lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and d for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months? 3 🗌 Ectopic pregnancy Pregnant at time of death 2 No Month Day 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 X No 2 🗌 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence မ 1 Yes 1 inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of Injury Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 XNatural 5 Pending investigation (Month, Day Year) Injury 2 Accident 1 Tes 2 No 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital
within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) 29b. Signature and tipe of certifier

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

strar's Signature

GML

STEPHANIE

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

2010

February 16

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DEANNA M. BAILIFF Physician/ Month FEB 2010 5:38P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 133 CINDER RD. TIMONIUM 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Sept. 22, 1947 1 M 2 X F Months Days Min. 217-48-5251 62 Marvland Yrs. Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exminer must be notified at once. once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Timonium Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 133 Cinder Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes XX No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 🗏 🏝 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12 yrs. College (1-4 or 5+) Homemaking ~Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey Samuel Myers Madeline Barbara Euler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa B. Bailiff (Daughter) 133 Cinder Rd. Timonium, Md. Page 1 and 2 21093 20a. Method of Disposition

X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory Dulaney Valley M.G. 2~27~10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ਟਿਕਾਂਡਰਜੀਮਕਾਂਸਿਆਂ ਸਿੰਘ Home 7401 Belair Rd. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pitysician/ disease or condition resulting in death) YEARD Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi): attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated to page 2 should to 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7

Registrar DHMH 17 Rev 7/2009

State

EBRIGHT

BRADFORD 31. Date filed (Month, Day, Year)

FEB 24 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LOUISE 2010 ebruaru /Medical 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Country) Social Security Number Cheverly er 1 Year | If Under 2 Hrs. George 5 If Under 1 Year 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 M 82 080-24-147 Director March 14, 1927 Vicquina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ Ño Maryland 1 10e. Street and Number 10g. Citizen of What Country? United States 20772 Completed by Funeral 12611 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □No permit. Pages 1 and 2 should be filed within 72 hours aften Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or in any injury or other traumatic event, the Medical Experimence. 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homema Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blake Isaiah Del ည avenport 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter Skinner Marlborg 20172 Irumbull 4 md. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State February 19, Baptist Church Glovcester. 4 ☐ Donation 5 ☐ Other (Specify) 2016 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Howard Funeral 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of Tying, such as cardiator respiratory frest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or s a consequence of): 5 Months disease or condition resulting in death) /Medical Examiner 2 years stroesoppagea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Physician: The law requires that the death certificate be executed the burial-transi 2 years Parkinsons Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident învestigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🖂 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

of Vital Records. Hospital or Attending P 4 hours after death. Funeral Director: After t iely filled in by the funera Division within 24 hours

> State Registrar

29b. Signature and title of certifier

Revathy

24 2010

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

y M.D. 6130 32. Registrar's Signature

Landove

29c. Lîcense number

29d. Date signed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1500 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Montgomery Takoma PArk 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 MM 2 🗆 F 11 25 1953 Months Days Hours Min. 56 257-82-5119 Director Georgia Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No D.C Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6505 14th. St. N.W. 20012 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 XNo þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black. "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "natu any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Private Tutoring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Lee Jenkins Jimmie Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6504 14th. St. N.W. Washington, D.C. 20012 Jessie Barnes/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Gate of Heaven Cem. 02-25-2010 Silver Spring, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee markall M6097 4217 9th. St. N.W. Washington, D.C. 20011 23a. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MOCHEDIAL INFARCTION ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as e consequence of): cause. Enter Underlying Exami Cause (Disease or linjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, HYPERTENSION 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Was an page 2 s has autopsy HYPOR CHOLESTEROL EMIA performe this certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D40324 FEBRUARY 19, 2010

DHMH 17 Rev 7/2009

State

Registrar

anko

7600 CARRELL AVENUE, TAKONA

PARK, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Pegistrar's Signature

TERRAL JODRIC, MD, FACEP

FEB 2 4 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a-30 per dr. 12900, 02/24/2010dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Mary E. Bennett 2010 11:32 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Month Day, Y Min. 1 M 2 X F Hours Virginia 215-36-3711 Director 71 May Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Poolesville MD Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 19141 Hempstone Ave. 20837 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 K Married þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) assembler electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bailey Criggar Lucille Meredith should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is 19141 Hempstone Avenue; Poolesville, MD 20837 James Bennett/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖺 Other (Specify) In State cemetery, crematory or other place, injury or Department of Important: If any injury or Sign true of Funer Service Licensee 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street Director Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician, Acute Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dee to (or as a consequence oi). Exal and bunial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? detached for Month Day Year Yes 2 No the P.O. nis certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hypertension Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA ည After this funeral of of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural (Month, Day, Year) or Attending 5 Pending work' Division death. 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director, the 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) D64235 February 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FFR 24 201

3.4

32. Registrar's Signature

Joel E. Buzy, MD, 9901 Medical Center Dr., Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Februar Physician/ 5.15PM 2010 rian Medical 4a. Facility Name (if not institution 4b. City, Town, or Location of De 4c. County of Death Examiner Sinai Bathwork Howere 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Min. Months Hours 1 MM 2 🗆 F 21 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mendial Hygiene. Important: I item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 10e. Street and Number Funeral 2124 1 Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Known AS: Brian 11. Marital Status Armed Ford 1 Yes If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed Blac Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) lanac Be 17. Father's Name (First, Middle, Last) 18. Mother's Name First, Middle, Maiden Surname, ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) onda 10 Place of Disposition (Name of Cometery, crematory or other) Date 20c, Location - City or 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State rownsvi 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility mo 21/33 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner e months Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 🗌 No 1 L Yes 2 L 9 L Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the Date signed (Month, Day, Year) 29b. Signature and title of certifie ٥ 10,2010

DHMH 17 Rev 7/2009

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State

Registrar

Sinai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 24 2010

KOTZ

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month February P^M Physician/ 2010 12:45 Jacqueline Borro Medical 4c. County of Death Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Rockville 27 Hawthorn Court 9. Birthplace (State or Foreign 8. Date of Birth Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. July 8, **Funeral** Days Hours 1 □ M 2 🗓 F Months 1965 Washington, D.C Director 214-60-2235 44 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 X Yes 2 ☐ No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20850 United States 27 Hawthorn Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married ģ Specify: White 1 X Yes 2 □ No Specify: Argentinian If Yes Give Completed 3 - Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) President/Manager Lola-Cafe and Bakery Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Emilio A. Borro Lucia Moya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hawthorn Court, Rockville, Emilio A. Borro/Father Maryland 20850 February 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, 2010 Bethesda, Maryland 22 Name and Address of Facility bert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, 21. Signature of Funeral Service Live MD 20850 M01530 May 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Ph_sician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **6** 2X No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 은 After this 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Af ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🖂 only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie (_ February 22, 2010

State Registrar inesta

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Minetta C. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

DHMH 17 Rev 7/2009

MD30061

3800 Reservoir Road NW, Washington, D.C. 20007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ho2. Date of Death Physician/ Day CUSEVECT BALISTON Medical 4a. Facility Name (if not institution, give street and number, Examiner Town, or Location of Death 4c. County of Death 05 timore 8. Date of Birth (Month, Day, Year) If Unde 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours Carolina 69 Director 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 ☐ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT, use retired) (Specify only highest grade completed) if Health and Mental Hygiene. /Seconday (0-12) Flementary College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Sister) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 120 injury (21. Signatu o Funeral Service Licensee Name and Address of Facility Seph. L. Russ Joseph 23a. Part 1. Inter the disease, cricomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVE Physician/ disease or condition resulting in death) R ANCER ひいへてた Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the property of the conditions of the condi Examine Due to (or as a consequence of) for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) a \ Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEPATITIC Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No After this certificate has page 2 autopsy Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No ပ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending 2 🗆 No 24 hours after death. Funeral Director: A ☐ Accident ☐ Suicide within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 129071 2-18. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FUTAN ST 4305 BALTIMENT SHNM 82 32. Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 04: 25 AM 2016 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth Month, Day 7. Age (In yrs. ast birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2□ F Director Usual Residence of Decedent 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the "Modical Examinations to notified at 1 Yes 2 □ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 X No þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) bore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City octown, State, Zip Code) Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury o 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee Joseph L. Kus 2222 W. North Home Funeral Ave. Balto. 23a. Part 1. Ever the Alsease, occomplications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician as the burial Physician/Medical attending p for use as 1 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.0. 1 □Yes 2 □No 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 1 ☐ Yes 2 🗆 No 2 No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this filled in by the funeral d After this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. .18,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ク 1emorial 32. Registrar Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 4:10 P M am February 20 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospita N/A Baltimore If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 ☑ M 2 ☐ F (Month, Day, Ye Hours 218-22-5936 82 Marvland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XX No Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 1707 Drexel Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married XX Yes 2 ☐ No If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 🔀 No Specify: Specify. 3 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Tractor Operator 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elise St. John Elihu Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1707 Drexel Road Dundalk, Maryland 21222 1707 Drexel Road Dundalk, Maryland Mrs. Phyllis G. Blevins (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 13万8Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 2/24/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 21222 Dundalk, Maryland 7922 Wise Ave. -22 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death month disease or condition

Physician/ Medical

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certificate

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Physician/

Medical

Director

Funeral

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

in the past 12 months?

Yes 2 No 9 🔲 Ünknown

Other significant conditions

resulting in death)

cancer ve pulmonary disease

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant þ Certificate: To Be Completed

9 🗆	Olikhown					
ontributing	to death but	not resulting in	the unde	rlying ca	use given ir	Part I.
_						

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No

1 Yes

23d. Date of delivery

Day

Year

Month

25. Was case referred to medical examiner?			
1 ☐ Yes 2 ☑ No	Hos	spital:	ER/Ou
27. Manner of Death		28a. Date of injury	28b. 7

Other: 4 Nursing Home 5 Residence 6 Other (Specify) tpatient 3 DOA 28c. Injury at 28d. Describe how injury occurred

Hanover Street Baltimore

26. Place of Death (Check only one)

Yes

Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Pregnant at time of death

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29b. Signature and title of certi

29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brinton

. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

Division of Vital Records, P.O. Box 68760

The law requires that the death certificate be executed Hospital or Attending Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05258 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marcella Julia Butcher Day 3:30P M 2010 Feb. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. 1916 Penhall Road Dunda1k Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country)
Cost Virginia Days 1 M 2 XF Months Hours Min. (Month, Day, Yea Director 86 236-30-4018 1923 West Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. Count 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Dunda1k 1 Tes 2 No MD Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 1916 Penhall Road 21222 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify Specify: 3 St Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even မ Emma Joseph Sammons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcella H. Kearney (Daughter) Dundalk, Maryland 21222 21 Mavista Ave. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2/16/2010 Towson, Maryland Hilltop Service Corp: Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk, Maryland 21222 9 Dunda1k Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law thours after death. Funeral Director: After this certificate has page 2 autopsy perform 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature

Margaret

31. Date filed (Month, Day, Year)

FEB 24 2010

inm

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sch

0

32. Registrar's Signatüre

29d. Date signed (Month, Day, Year,

9512 NARFORD RD BALL MO

3. Time of Death

MD

1 □ Yes 2 No

21208

Year

Approximate Interval Between Onset and Death

10d. Inside City Limits

Birthplace (State or Foreign Country)

WHITE

Year

20/0

USA

GARBIS

Month

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours after e Funeral Dire letely filled in b within 24 hor To the Fune completely fi

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Residence 6 Other (Specify) 28d. Describe how injury occurred 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 28 31. Date filed 2. Registrar's Sign **ORIGINAL**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Day Marland Edward Carlson 02 2010 Medical 11:25 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Quail Run Assisted Living Baltimore <u>Parkville</u> Social Security Number If Under 8. Date of Birth (Month. Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ▼ M 2 □ F Months Davs Hours Min. Country) Director 24 3206 80 06/14/1929 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits or 28a-f 1 🗆 Yes 2 🔀 No MD Baltimore Glen Arm 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11816 Manor Road 21057 U.S.A. items . Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Kore If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. . or Black, White, etc. Completed by 1 Never Married 2 Married 2 No Korean/ Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates.Vietnam the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Hoffberger Oil Co. Dispatcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Axel Gunnard Carlson Esther Christine Lofstrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 659 Carlton Trail - Bel Air, Maryland Noreen C. Odham (daughter 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State ō injury 4 ☐ Donation 5 ☐ Other (Specify) John Evan.Cem. 02/19/2010 | Hydes, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. ass 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami Physician: The law requires that the death certificate be executed the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death Other (specify) Year detached g 🗌 Unknown P.O. ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? Was an has autopsy certificate 1 Yes 2 🗌 No 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier within 24 hou

To the Fune

completed fil Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature an 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 21 2010 9:30 PM Physician/ Harold Garnett Campbell Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Overlea Health Care Baltimore Baltimore City 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Funeral EaSTEV SC Days Hours 1 € M 2 □ F September ^vzz 1934 216 30 2219 75 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Tes 2 No Maryland Baltimore Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21221 USA 947 Middlesex Road 12. Was Decedent Ever in U.S.
Armed Forces?

1 1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White Year or Dates. Korea Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Seconday (0-12) General Foreman & Operations VA Hospital (Washington DC) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ruby Pearl Teate Berry Edward Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21221 947 Middlesex Road Linda A Whatley (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Metro Crematory Inc. February 22 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to lor the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🗌 No s been signed by the sahould be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Jas director, page 2 1 ☐ Yes 2 ☐ No certificate I 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at/ 28d, Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 🗆 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) License number of certifier 29b. Signature

State Registrar 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month BRUARY Day 20. Physician/ Elizabeth Carter Thelma 00:50M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Towson timore Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Months Hours Ma(M°4th1922^{ear)} 1 □ M 2 🕌 F 87 Baltumore, Maryland 216 16 2326 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Baltimore County Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 Funeral 300 International Circle Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Gatch Memorial Un Meth. Ch. Secretary of Health and Mental Hygitem 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Lillian Lucille Trueblood ၉ Walter A Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 13037 Beaver Dam Road Cockeysville, Maryland 21030 (Daughter) Lynn E Bivona 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State Metro Crematory Inc. February 22 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) a re of Funeral Service Cocensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore Maryland 21236 23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 0 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. injury 1 Tyes မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural Accident 5 Pending death. 1 Tes 2 🗆 No Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37263

Registrar
DHMH 17 Rev 7/2009

State

DRIVE

TOWSON.

MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed (Month, Day, Year)

FEB 24 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month Physician 6:00 P. Joseph Mercer Claytor 2010 February 18, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Bay Ridge Nursing Home 8. Date of Birth (Month, Day, Year) 03/30/1932 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Mary land 1**K**]M 2□F Months 77 215 28 2092 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be approximated. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 X No Glen Burnie Anne Arundel Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21061 208 Ridgely Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Fire Department 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Claytor Beatrice Fonz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, Maryland 21061 Catherine Claytor / Wife 208 Ridgely Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 02/23/2010 4 □ Donation 5 □ Other (Specify) Holy Cross Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. ecome 4001 Ritchie Highway Baltimore, Maryland 21225 namuca 23a. Parn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for sela consequence Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Tyes 2 TNo 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1П Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 Yes PNo 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Medical Certification: (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

olet drive 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Klicott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:50PM VIA -2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death County of Death SAMARITAN Baltimore HOSPITAL (200D BALTIMORE 7. Age (In yrs. last birthday) 48 Yrs. 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🖼 Hours Min **Director** Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2115 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important; If item 27 is marken any injury or any injury o ည 19a. Informant's Name/Relationship (Type, Pfint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 etery, crematory Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facilit ndallstown, MU 21123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ENDOCARDITI disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician Physician/Medical certificate be the as IF FEMALE nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Hospital or Attending Physician: The law requires that the death ō Month Pregnant at time of death Day Year page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, TENSION ERE BROVASCUL Completed peen : 24b. Were autopsy findings available ACCIDEN 24a. Was an prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has performe 2 🗌 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 1 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifie 1 🛁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD RES 000 21 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI) BLUD BALTIMORE AROLINE D'SOUZA 5601 LOCH RAVEN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

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3.	r deat or iten iner r		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑		13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp ap, Mexican, Puert	oecify Yes or No o Rican, etc.)	-	14. Race - Ame Black, White	
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re,	1 and of Hea item		20a. Method of Disposition		20b. Plac	ce of Dispo	osition (Name of matory or other place		Date	_	Location - City or	
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JO _	Jing F n. After funera	Certificate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of inju (Month, Day	ry , Year)	Bb. Time o injury	work	y at (? Yes 2 🗆 No	28d. Describe	how inju	ry occurred	7
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exan	vsician: To the best of niner: On the basis of earse Practioner: To the	xamination ar	nd/or inves	tigation, in my opinio	on, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated.
	Vithi Vori		29b. Signature and title of certifier		Ve		29c. License			29d. D.	ate signed (Monti	
			Deorge FIMI	(awirm)			1000	5947	1		21/10	
	10		30. Name and address of person who		eath (Item 23	3a) (Type, I	Print)	On of	11.7	<u></u>	(50= -07)	1021204
	(31. Date filed (Month, Day, Year)	Wind Registre			J. Mari	21.	uu, l		1309/10	4) 2101
	Stat		EER 9 4 2011	32. Registra	a a Signature	Day						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 11,42 AM February 21 9 erie 2010 /Medical 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Kandallstown tos pice easons 8. Date of Birth

(Month, Day Year)

7-3-96 9. Birthplace (State or Foreign If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min Days MD 213-84-9223 1 ☐ M 2 🕶 F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow th and Mental Hygiene. ?7 is marked other then "naturel", or items 23a or 28a-1 ehov treumatic event, it a Medical Examinar must be notified at Baltimore 1 Ses 2 No MD Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 200 N. enison 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Peges 1 end 2 should be filed within 72 hours effer c Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel; or Item eny Injury or other treumatic event, Ita Mudical Examina-1 Never Married 2 ☐ Married I □ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame Father's Name (First, Middle, Last) Be oris .uther 2 19a. Informant's Name/Relationship (Type, Print) (Daughler) 19b. Mailing Agress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 20c. Location - City or Twn, State 20b. Place of Disposition cemetery cremator nod of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licenses Nat'l Pike BW Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Malianant Neoplasm

Due to (a as a consequence of): of Unknown Origin **Physician** /Medical Examiner frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner I or Attending Physiclen: The law requires that the death certificate be executed after death.

Director: Atter this certificate hes been signed by the attending physicien and in by the funderal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Portal 24a. Was an Thrombosis Vein autopsy performed' 2 No 2 No Hydronephrosis 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 00th (1500th) Hospice Hospital: Other: 1 ☐ Yes 2 🗷 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel Completely filled in the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0053337 2010 February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seite 203 Bultinune, Avenue 2835 M 31. Date filed (Month, 32. Registrar's Signature back State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 2010 5:15 ΡМ Greta Pratt Call 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F Months Davs Hours Min. June 15, 1921 Pennsylvania 225-90-3301 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland | Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 United States 7328 Blanchard Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Homemaker & Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Avery Pratt Eliza Wickham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Call/Son 7328 Blanchard Drive, Derwood, Maryland 20855 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. 2010 Bethesda, Maryland Signature of Funeral Service License Robert A. Fumphirey Funeral Home/Rockville, Inc. M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Fibrosis resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that initiated events Due to (or as a consequence of) resulting in death) Last

Physician/ Medical Examiner Examine

Physician/

Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

"natural",

other traumatic event, the Medical

permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "na any injury or other traumatic event".

Examiner must be notified at

Director

Funeral

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Completed

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should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

attending physician and for use as the burial-transi ate has been signed by the apage 2 should be detached within 24 hours after death.

To the Funeral Director: After this

Certificate: To Be Completed by Physician/Medical

Medical

29b. Signature and title of certifier

31. Date filed (Month. Day, Year)

Kouce tchou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23d. Date of delivery Month Day Year									
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?								
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25. Was case referred to medical	26. Place of Death (Check only one)									
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27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigati	(Month, Day, Year) Injury work? on M 1 ☐ Yes 2 ☐ No	I. Describe how injury occurred								
3 Suicide 6 Could not 4 Homicide determine		. Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 Medical Example (Check 2 Medical Example)	ysician: To the best of my knowledge, death occured at the time, date and place, and d niner: On the basis of examination and/or investigation, in my opinion, death occurred at the rse Practioner: To the best of my knowledge, death occurred at the time, date and place, a	time, date and place, and due to the cause(s) and manner stated.								

D63748

29d. Date signed (Month, Day, Year)

February 19, 2010

State

DHMH 17 Rev 7/2009

Registrar

Jocelyne T. Kouatchou, M.D. 201 East University Parkway, Baltimore, MD 21218

			For State	State of M	arylan		artment of H		nd Me		_	0010	05268
	_	-	Registrar 1. Decedent's Name (First, Middle, I	Last)		Cei	rtificate of l	Death	2	Date of Dea	Reg. No	.2010	3. Time of Death
	Physici /Medic		Rayı		Month				Day Year				
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or					c. County of Death Montgome	
and the same	Funeral		Kensington Park 5. Social Security Number 6.		e (In yrs.	last birthday)	If Under 1 Year	singto		Date of Birl	- 1	-	place (State or Foreign
h	Director		209-16-2497	1四M 2□F	84	Yrs.	Months Days	Hours	Min. M	Date of Birl (Month, Da ay 4,	1 ⁹ 2	25 Penr	isylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	a-f sh	ctor	Maryland Montgo	omery			Kensingt	on					1 ∐Yes 2. No
	with the Ra or 28	I Director	10e. Street and Number 13616 Littleda	le Road			10f. Zip Code	20895			_	itizen of What Cou	
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H	ispanic Origi	in? (Specif	y Yes or No	- 1	14. Race - Amer	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Evanicar must be notified at once.	by Funeral	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced		No		1 □Yes 2🏝 No	Specify:	rueito nic	Jan, etc.)		Black, White Specify: [hite
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מש	al Hygi other	Be C	17. Father's Name (First, Middle, La	st)			01	18. Mother's	s Name (F	irst, Middle,	Maide	n Surname)	
ylaı	ould by I Ments larked	인	Renato Cardas							enzis			
Baltimore, Maryland	id2sh lthand 27is⊓ traum	1	19a. Informant's Name/Relationship Daniel Cardascia	'- * '		1	ng Address <i>(Street a</i> Castle Cl						ip Code) Cyland 20904
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ij	t. Pag tment tant: I		1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	Mei	norial	Park	1	201	0		kville,	
Ba	permi Depar Impor any Ir		21. Signature of Funery Service Lic		M001	98 R	58er ind Address 00 West Mc	Pulliplik ontgome	ey Fu ery A	ineral ve., R	Ho ock	me/Rockv ville, MI	ille, Inc. 20850-2805
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1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.			Heart Dis	ease					
7.	Examiner			Conges	tive	Heart	Failure						
	pe iii	iner	Sequentially list conditions, if any bearing to himsurate cause. Enter Underlying Cause (Disease or injury that initiated events	o. Oue to (or as								-	
B	execution and al-trans	Examiner	that initiated events resulting in death) Last	c. Alzhei									
68760,	ficate be executed physician and s the burial-transit	dical	Hypertension										
	ires that the death certific signed by the attending is i be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	Ideath 3	Ectopic pregnanc	y				23d. Date of deli	very Day Year
P.O. Box	t the de by the a ached t	hysic	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of d	leath 5L	Other (specify)						
Division of Vital Records, F	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	ğ	Part II. Other significant conditions Pulmonary Embo		ut not resi	ulting in the u	nderlying cause give	en in Part I.					the cause of death? obably 4 ☐ Unknown
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a H	n: The ficate h									perfo 1 □ Yes	rmed? 2 ⊠ N	death?	2 🗆 No
₹	hysician: The law his certificate has I I director, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2□	ER/Outpatier	ot 3 🗆 DOA Othe		- 100 man W - 1	Check only o		6 to Other (Spec	Assisted
n of	ding Phy h. After thi funeral c	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	ıry	28b. Time of Injury	28c. Injur	y at				ury occurred	my hiving
Sio	ttendli death. tor: A	icatio	2 Accident investigat 3 Suicide 6 Could not	he	At he		M 1 🗆	Yes 2 □N			24	- 111 1	10. 1 11
<u>≥</u>	al or A s after I Direct	Certification: To	4 ☐ Homicide determine	building, et	c. (Specif	y)	eet, factory, office		201	City or Tov	vn, Sta	and Number or Ru te)	rai Houte Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner st	of examina	wledge, deat ition and/or in	h occurred at the tir vestigation, in my o	me, date and pinion, death	l place, an n occurred	d due to the at the time,	cause date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	000	(n	-	29c. Licens	e number			29d. D	ate signed (Month	, Day, Year)
			· Th	77 100	H	-	_ D53	691			Feb	ruary 8,	2010
	15+1		30. Name and address of person when Ajay Reddy, M.D.				Print) vd.#110,	Rockvi	ille.	Marv ⁻	Land	1 20852	
ř	Sta		31 Date filed (Month Day Year)	22 Pogiete	are Signo	turo			,	u- j -			
	Registr	ar	EER 0	4 2010	- secre	1.	Darke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02 2010 Year 19 MERLIN JUNIOR CRITES 8:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8538 Neptune Dr. Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 02 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1**⊠** M 2□ F 233 50 3338 74 1935 WVA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8538 Neptune Dr. 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Appliance Assembly General Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Crites Not Available 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Crites - wife 8538 Neptune Dr. Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Bayview Crematory 2/22/10 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Funeral envice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ncinon disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): outcome of pregnancy ive birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day regnant at time of death Inknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 MNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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ss 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expendence must be notified at

altimore, Maryland 21215-0036

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi The law requires that the death certificate be executed P.O. Box 68760 of Vital Records, certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division

Examiner Physician/Medical φ Be Certification: To

F FEMALE: :3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, 1
1 □Yes 2 □No	

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Déscribe how injury occurred

27. Manner of Deeth 5 Pending investigation 1 ☐ Yes 2 ☐ No 2. Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifier

D39505

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

February 22, 2010

31. Date filed (Month, Day, Year, FEB 24 2010

29a. Certifier

305 Hospital Dr, Glan Burnie, MD. 21061 32. Registrar's Signatur

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:38 РМ 18 2010 Feb PAUL BERNARD COUTURE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 107 Sandv Beach Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 MM 2 □ F 12/01/1923 Rhode Island Director 039-07-1441 86 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? ō 23a 107 Sandy Beach Drive 21122 U.S.A. Funeral items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ō 1 □Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1947 "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event experience." (Give kind of work done during most of working life. DO NOT use retired) Verizon College (1-4or 5+) Elementary/Secondary (0-12) Cable Splicer 12 <u>Telephone</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ Joseph Couture Roseanne Allard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Sandy Beach Drive, Pasadena, MD 27 Pasadena, MD 28 Pasaden Betty Leifter Couture/Wife
20a. Method of Disposition
1 Burial 2 Foremation 3 Removal from State MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 02/19/10 Bayview Crematory Baltimore, MD 22. Name and Address of Facility G.J. Gonce Funeral Home, 21. Signature of Funeral Septine Licensee <u>169 Riviera Drive, Pasadena MD 21122</u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final WCER 88A716 **Physician** LUN 6 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical e attending p d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Dav 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ≥ ANURIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed neec HYPOTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 ∐Yes 2.2XNo 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After the 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

HTI State

Registrar

29b. Signature and title of certifier

30. Name and address of person who

· · · No 31. Date filed (Month, Day, Year) FEB 24 2010 80

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32. Registrar's Sig

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completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month. Day, Year)

It Smallwood Rd Stel Pasaderamo

			For State Registrar	State of N	Maryland / D		ment of He ficate of L			iene eg. No20	0	052	271
г	Physici	an	Decedent's Name (First, Middle, Las						2. Date of Dear Month	Day	3. Time of Dea		
	/Medic	al	RANDOLPH	ty Name (If not institution, give street and number)			ELAND	Location of Death		Y 18, 20		6:02	A ^M
	Funeral	er	PRINCE GEORGES I 5. Social Security Number 6. Se	HOSPITAL	CENTER Age (In yrs. last birti	hday) I	CHEVER		8. Date of Birth	PRINCE GEORGES f Birth n, Day, Year) 9. Birthplace (State or Forei			or Foreign
	Director		213-68-1458 Usual Residence of Decedent		53				10-13	- 1956 │	MARY	LAND	
	arylan show d at	_	10a. State 10b. County		10c. City, Town						1	0d. Inside Ci	ity Limits 2 ☐ No
	the Ma 28a-f	Director	MD • PRINCE GI	EORGES	HYAT		LLE 10f. Zip Code		1	0g. Citizen of W	hat Cour		
	3a or	Ö	4906 69th PLACI	E			20784			USA	nat oour	iuy:	
after deat	ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Deceder Armed Forces 1 XYes 2 If Yes, Give	s? □ No POST—	If Y	es, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		, White,		
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Ž	2 should and Men Is marke	To	RANDOLPH HIGH MYRTLE HARROD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Print)							; City or Town, S	State, Zip	Code)	
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altimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑	Removal from Stat	20b. Place of cemeter	Disposition, cremat	on (Name of ory or other place	3-2-	Date 2010	20c. Location - 0	City or To	own, State	
ţ	t. Pages rtment of rtant: If it		4 □ Donation 5 □ other (Specify)	GARRIS		REST VE			WINGS M			(LAND
Ba	permit. Pages Department of Important: If it any injury or once.		21. Signature of Fune al Service Licen	ONATHAN CAR	I D. HIBN				LLIPS FU T. BALTI		•		1217
	5.50		23a. Part Enter the disease, or comp	olications that caus	ed the death. Do n							Approximat Interval Bet	
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Division or Vital	l or Attendafter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I	injury - At home, far etc. <i>(Specify)</i>	m, street	, factory, office		28f. Location (S City or Tow	reet and Numbe n, State)	r or Rura	al Route Nun	nber,
	pital o		29a. Certifier 1 Certifying Phy	vsician: To the be	st of my knowledge	death o	ccurred at the tim	e, date and place	and due to the o	ause(s) and mar	ner as s	tated	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)	niner: On the basis and manner	of examination and	d/or inves	tigation, in my op	inion, death occu	rred at the time, o	ate and place, a	nd due t	o the cause(s)
	To the To the Complex	Me	29b. Signature and title of certifier	-			29c. License			9d. Date signed EBRUARY			
			· gv		- ino					PDVOWLI	17,	2010	
	411		30. Name and address of person who c					ET NW, W	ASHINGTO	N,DC 204	22/6	588	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 24 2010	Server 32. Regis	Strap Signature	Les !							

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aurice Davis	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death									
Physici	an/	Registrar		Dealit		Reg 2. Date of Death	No.	3. Time of Death		
edical Exami		Maurice Davis				Month [February 18	Day Year B, 2010	2239 hrs		
		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or L			4c. County of Death			
		Northwest Hospital		Randalistowr		10.0	Baltimore Cou			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24H Hours N	lin. 40 Birth	Foreig			
Director	,	217-53-7335 1× 20F	Yrs.			Junea	19981 6	ountry) Na.		
*un		Usual Residence of Decedent 10a, State 10b, County 10c, City,	Town or Location	on	-			10d. Inside City Limits		
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Maryland 28a-f show any d at once.	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?		
the Nation	Dir	9017 Samoset Rd.		211:	33		USF	7		
eath with the items 23a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Status 15. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.)								
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Baltimore, MD 21215-0036 sermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho nijury or other traumatic event, the Medical Examiner must be notified at once.	o Be	19a. Informant's Name/Relationship (Type, Print) grandmether	19b. Mailing	Address (Street:	and Number of	r Rural Route Numb	or Len er, City or Town, State	. Zip Code) 7 11 2 2		
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Box 6876 he death certificate the attending phy hed for use as the b		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnation to 23c. If yes, outcome of pregnation to 25c. If yes, outcome of yes, outc		al death 3	Ectopic preg	nancy	23d. Date of deliver	y Day Year		
Box 6876 e death certificate the attending phy ed for use as the l	sician/M	past 12 months? 1 Yes 2 No 9 Unknown a Unknown	=	er (Specify)						
D. Bc t the dea by the a	Phys	Part II. Other significant conditions contributing to death but not res	culting in the ur	dorlying cause giv	en in Part I	23e Did toba	acco use contribute to	the cause of death?		
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Division of Vital Records, as of Attending Physician: The law require is after death all Director: After this certificate has been sited in by the funeral director, page 2 should be	o Be	examiner?	ER/Outpatient	3 DOA O	ther Nur	sing Home 5 Re	esidence 6 Other	ń.		
ding Ph	-	27. Manner of Death 28a. Date of Injury	28b, Time of In			28d. Describe hor				
Sion Attendi er death rector: A	Certification:		FOUND: 2203 hrs	1 Ye	s 2 🗸 No					
28. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)										
Division To the Hospital or Attency within 24 hours after death To the Funeral Director:	Cel	4 Homicide determined (Specify) Residence					Road, Randallstown			
To the Hos within 24 h To the Fun completely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and								
To To	Mec	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mo.	nth, Day, Year)		
		Shedow MIK 1 TO)	O.C.M	.E.	DOME	February 19, 201	10		
1		30. Name and address of person who completed cause of death (Item		1		1904				
\		Theodore M. King, Jr., MD. Assistant Medical Ex		111 Penn Stre	et, Baltimo	ore, MD 21201				
St	tate	31 Date (Honth, Day Year) 32. Registrar's Signatur	e							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:55A Judy G. Erbe 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17 South Washington Street Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** 1 M 2 X 1950 New York Director 123-40-5886 Aua. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No New York Chenango Afton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 491 Algerine Street 13730 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Ş 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. "natural" 3 Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald Green other traumatic Dorothy Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremy McKown <u> 26Monroe Street, Hoboken, New Jersey 07030</u> Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ō injury EvergreenHillCemetery2-26-10 Unadilla, New York Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A nichal Road, Baltimore, Maryland21214 6009Harford 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or a consequence of) Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death detached 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, law requires 2 No 3 Probably 4 Unknown Completed 1 Tes page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? certificate 2 🗌 No 1 🗌 Yes Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} Other: မ Other (Specify) JaH 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the f Investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (M Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 2 20:02 James W. Everett 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Hospital Baltimore Union Memorial 8. Date of Birth
Jan. 4, 1923 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 🛛 M 2 🗆 F Months Hours 87 Director 212-12-0554 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 U.S.A. 5611 Walther Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 10 ğ Baltimore, Maryland 21215-0036 If Yes, Give 1941–1946 Year or Dates. 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Baltimore Citv Elementary/Seconday (0-12) College (1-4 or 5+) Fire Boat Fire Department 8 Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important If item 27 is marked oth any nitany or other traumatic event once. ည Jaskiewicz James Henry Everett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>8527 Westerman Circle Baltimore, Maryland 21236</u> <u>Roseanna Everett - Daughter</u> 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery: 02-23-2010 Overlea, Maryland 4 Donation 5 Other (Specify) 21. Signatu of 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate nterval Between Onset and Death Physician cute disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner displacement been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed al infarction Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate has or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) of Vital funeral director, Certificate: To Be examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \(\subseteq \text{Other} \(\subseteq \text{Cpecify} \) 1 🗌 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral injury $5 \square$ Pending Division Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 I Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospita 31. Date filed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 22 2010 05:30 AM EPSHTEYN MARIA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6978 MARSUE DRIVE, BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 □ M 2 🗓 F Months Country) 0870871923 **BELARUS** Director 213-35-5354 86 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho Funeral Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BELARUS 6978 MARSUE DRIVE, 21215 #2B 12. Was Decedent Ever in U.S. Armed Forces of 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 ltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BENJAMIN **EPSHTEYN** RAHIL DRECHEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MOSEY STEYNMAN / HUSBAND 6978 MARSUE DRIVE, #2B, BALTIMORE, MD 21215 injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or otl ARCTNGTON CEMETERY CHIZUR AMUNO CONG. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/23/2010 BALTIMORE, MD gnature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 as Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between 23a. Part 1. Enter the disease set and Death Immediate Cause (Final disease or condition Physician. DAYS Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examiner Due to (or as a c ears sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 🔀 Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) mature and title of A-KENDING カリフリロ 22, 2010 completed cause of death (Item 23a) (Type, Print) 30. Name and ad

State Registrar 31. Date filed (Mor

M.D.

3512 Newland Rd

21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nd item 5 per inf 9904 6-8-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ JEAN D. FERRIS 3150 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sanare 3alt Coseda more 1920 TR If Under 1 Year | If Under 24 Hrs. 212-28-6666 218-22-22 Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months Davs Hours Min. 8 - 13 - 1 9 3 0 MARYLAND 79 Yrs. Director Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland ms 23a or 28a-f shor must be notified at Director MD BALTIMORE ROSEDALE 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8425 COCO ROAD 21237 U.S.A. tems death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No traumatic event, the Medical Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes XXNo Specify: If Yes Give Specify: WHITE "natural", Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ျှ **MESSER** (JOHNSON) HOMER MARY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 19a. Informant's Name/Relationship (Type, Print) 7002 GREENBANK ROAD MIDDLE RIVER, MD R. SCOTT FERRIS/SON Important: If item 2 any injury or other tonce, other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 2-27-10 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licenses 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 1 Yes 2 1 No ER/Outpatient 3 DOA မ 2 🗌 After this 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniury 1 Natural 5 Pending 24 hours after death. Funeral Director: At Accident
Suicide Investigation completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge death occurred at the time detained plane, and due to the cause(s) and manner as stated (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) L'n, e500000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 9000 21237 WD 31. Date filed (Month. Registrar's Sign State Registrar

			For State	State of M	laryland / Depa			d Mental H	ygiene 🚄 🛚	JIU	0321	
			Registrar 1. Decedent's Name (First, Middle,	Last)	Cei	tificate of	Death	2 Date of D	Reg. No. 2. Date of Death 3. Time of			
	Physici Medi		Elizabeth G	riffith Fit	zgerald				ry 2Pay 20	10 ^{Year}	3. Time of Death 2:36 A M	
4	Exami	ner	4a. Facility Name (If not institution, of Byron House	give street and number)		4b. City, Town, o		eath		ity of Death		
	Funeral		5. Social Security Number 6	6. Sex 7. Ag	je (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of B	L	9. Birth	place (State or Foreign	
	Director		216-12-3396 Usual Residence of Decedent	1 L M 2 LAF	91 Yrs.	World Bays	Hours	Feb. 17	, T919	Wash	ington, D.C.	
	and show	Ď	10a. State 10b. County	_	10c. City, Town or Lo	cation					10d. Inside City Limits	
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	th the	Funeral Director	10e. Street and Number	"		10f. Zip Code			10g. Citizen o		,	
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9	er dez or ite miner	by Fi	1 Never Married 2 Marrie	Armed Forces?	No.	f Yes, specify Cub	an, Mexican, Po	uerto Rican, etc.)		ace - Ameri ack, White,		
93	ural", ural",	ed	3 🛚 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		I□Yes 2 🛭 No	Specify:		Specify:		ite 	
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yla	uld be Ment narke	욘	C. Dade Griff	Waters								
, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship William A. Pumph		phew 19b. Mailir	ng Address (Street 6 Spates	and Number of	Rural Route Numb oad, Pool	er, City or Town, lesville	State, Zip • MD	^{Code)} 20837	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	Removal from State	20b. Place of Dispo Montgomer Cremator	sition (Name of natory or other pla	^{ce)} Fel	oruary 22, 2010	20c. Location Bethes	,	own, State ary1and	
Balti	permit. Departn Importa any injt		21. Signature of Funeral Service Lie	gsee .	M00803 RO	Name and Addre	ss of Facility Imphrey F		e, Bethese	da-Chev	y Chase, Inc.	
	Physician/ Medical Examiner	16	23a. Part 1. Enter the disease, or coshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ly one cause on each line Fail a. Due to (or as b.	e. ure to Thri a consequence of): rtension		ng, such as care	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death	
£ 091	cate be executed physician and s the burial-transit	edical Examiner	if any, leading to immediate case. Enter the drying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	Arthritis Due to (or as a consequence of): Hypothyroid							
. Box 687	or Attending Physician: The law requires that the death certificate be executed affect death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnan Other (specify)	су			ate of deliv	ery Day Year	
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cord	law requires the has been signer 2 should be	Completed by						24a. Was	s an 24b	. Were auto	psy findings available impletion of cause of	
Ä	sician; The la certificate ha rector, page?		25. Was case referred to medical				lana of Danth //		formed? 2 X No	1 Yes	2 🗆 No	
Vita	ysicia is cert directe	To Be	examiner? 1 ☐ Yes 2 🕅 No	Hospital:	ent 2 ER/Outpatier	Oth		Check only one)	idence 6 🕅 Ot	her (Specifi	Asst. Living	
on of	nding Ph ath. r: After thi e funeral	Certificate: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of inju (Month, Day	ry 28b. Time of	28c. Injur worl	y at		how injury occur		,	
Division of Vital Records,	ial or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, stre c. (Specify)	t home, farm, street, factory, office 28f. Location (Street and Number or Bural Re					l Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 L Medical Exa	Physician: To the best of aminer: On the basis of elurse Practioner: To the	xamination and/or invest	igation, in my opini	on, death occuri	ed at the time, date	and place, and d	ue to the ca	use(s) and manner state	
			29b. Signature and title of confifier			29c, Licens D5979			29d. Date signo Februa			
	10		30. Name and address of person where Le Le Luu, M.D.		eath (Item 23a) (Type, Pen Locks Ro		, Rocky	ville, Ma	ryland	20850)	

Registrar

EB 24 2010 Jenera

original

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 2:52 \mathbf{A}^{M} Gene Arnold Flick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 28, 1934 . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours Ohio **Director** 190-24-8892 76 Usual Residence of Decedent "natural", or items 23a or 28a-f show incal Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 3 Stevens Court 20850 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1953–1961 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 4 Food & Beverage Director Hotels 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnold Lee Flick t. Page 1 and 2 should be thrent of Health and Men rant: If item 27 is marke Mary Margaret Laughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevens Court, Rockville, Maryland 20850 M. Joyce Flick/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If i
any injury or c cemetery, crematory or other place) February 24, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park 2010 Rockville, Maryland Signature of Funeral Service Licensee Range and rumphires Funeral Home/Rockville, Inc. the 300 West Montgomery Avenue, Rockville, Maryland 20850 M01548 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Pnysician/ Medical Myelodysplastic Syndrome disease or condition resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death for in the past 12 months? Month Year Pregnant at time of death Yes 2 No the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate It 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 🗌 Yes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pleted filled in by determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Physician: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) · Koucetche u, mo 1) 63 748 February 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne T. Kouatchou, M.D. 201 East University Parkway, Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **EER 24** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 05279 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 3:43 pM Kobert February 20 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ullstown Baltimore 8. Date of Birth (Month, Day, Yea 5/19/1957 Birthplace (State or Foreign Country) If Unde 5. Social Security Number 6. Sex 1M M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days Min Months 216-66-7083 52 Yrs MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** MD BALTIMORE RANDALLSTOWN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō death with 12 AVENTURA COURT 21133 USA "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event, the Maonce. Elementary/Secondary (0-12) College (1-4or 5+) PRINTER PRINTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RICHARD DANIEL FOLKOFF SALLY ANN FLOAM ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH FOLKOFF/WIFE 12 AVENTURA COURT, RANDALLSTOWN, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State CARROLL CREMATION 2/23/2010 HAMPSTEAD, MD 4☐Donation 5 ☐Other (Specify) 1. Signalure of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atheroscleroto curdiovascorer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 146655644 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific *2010* 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Cook Rd Randallstown MD

State Registrar

Novteneest Hospital 31. Date filed (Month, Day, Year)

32. Registrar's Signature

5401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2000 Physician/ 0400 ON IBSUA OH NNY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Tate Hospice House Linthicum Heights 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Feb. 5, 1950 Days Hours 1 ☑ M 2 ☐ F Months Tennessee 213-48-4622 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County 10a. State with the Maryland **Funeral Director** 1 🗌 Yes 2 🔼 No Examiner must be notified Catonsville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 23a **USA** 21228 805 Bobby Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc 1 Never Married 2 Married þ 1 Yes If Yes, Give White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Transportation Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thelma Jo Trent ည Hugh Parlan Gibson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Bobby Road; Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print) Mary Gibson Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland 2/24/2010 Donation 5 C Other (Specify) Glen Haven 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21 Signature of Funeral Service Licenses 23a. Part 1. Enter the diseas or complications that cand the death. It not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death NUNTHS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate
Cause (Disease or iinjury attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Oth 1 Inpatient 2 I ER/Outpatient 3 I DOA ပ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death House Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account and the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cenifier

State Registrar . Name and address of person who oor

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

ENSE

peted cause of death (Item 23a) (Type, Print)

1ENTA M441

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAMES E. GALLUP, JR. ΜΈΒΒ. 2ďTb 3:30P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 6502 Corkley Rd. Rosedale Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1XXM 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Feb. 17 Yel 941 Marvland 214-38-2657 Yrs. 69 Director Usual Residence of Decedent Show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6502 Corkley Rd. 21237 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2XX Married Yes 2XXNo Baltimőre, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A 12th grade Self~Employed Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James E. Gallup, Sr. Ethel B. Hammen Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine J. Gallup (Wife) 6502 Corkley Rd. Baltimore, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 2~26~2010 Baltimore, Md. Ag atue of Funeral Service Linesee Name and Address of Facility Home Tassann roncid. 7401 Belair Rd. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final UNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam signed by the attending physician and the detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant a
9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d, Describe how injury occurred 12 Natural 5 Pending 1 Yes 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

the

State Registrar Check

only one)

31. Date filed (Month:

29b Signature and title of certifier

DHMH 17 Rev 7/2009

completed cause of death (Item 23a) (Type, Print) 9106

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

36 U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 006/1 FEBRUARY 2010 14 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 ANDALLS TOWN OLD COURT NA AL FUTURE CARE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Sept. 26 6. Sex **Funeral** Min 1 □ M 2 🕅 F North Carolina **Director** idence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) (First, Middle, Maiden Surname) ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 (Son 19a. Informant's Name/Relationship (Type. Print) Mr. Donel WOODA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location 20a. Method of Disposition 2/20/ 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State en Mount Crematory 21. Signatur Juneral Service Linesee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed Box 68760, 名 burial-trar Due to (or as a consequence of): attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 1□Yes Records, P.O. 9□Unknown 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 al Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed? this certificate 2 No Division or Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2200 3□ D0A 1 ☐ Yes 1 Inpatient 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Peath 1 Natur I 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAWAMUS TONO

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygierie 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GLADNEY **Physician** IAMES 8:15 PM FEBRUARY 17 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) OCT 29 19 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) ¹XXM 2□F Days Hours Yrs. Director 77 SOUTH CAROLINA 248-46-6330 1932 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at XXYes 2 □ No Director MARYLAND N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3319 MONDAWMIN AVENUE Items 23a 21216 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 122 Yes 2 □ No If Yes, Give Year or Dates: 53/55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "natural, or Iter 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2XNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown TRUCK DRIVER SAFTEY CLEAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN GLADNEY unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si nent of Heaith an ent: If Item 27 Is r Eloise Gladney/Wife 3319 Mondawmin Ave., Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Importent: If It any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03-03-2010 GARRISON FOREST OWING MILLS, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funda | Soldings see 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. lleun 1206 W NORTH AVENUE 23a. Pent: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the second conditions of the cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a gunsacuence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACUTE KIDNEY FAILURE 1 Yes 2 No 3 Probably 4 Winknown BRILLATION, CORONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? DISEASE 1 Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES 001 FEBRUARY, 17, 2010

Registrar DHMH 17 Rev 1/2001

State

3001 SOUTH HANOVER STREET, BALTIMORE

MARYLAND

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4^{Day} Month **Physician** 2010 Charlotte 3:50 рм R. Hammonds /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balto Riverview Nursing Home Essex 8. Date of Birth (Month, Day, Year) 3-17-1941 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 M 20 F 214-36-7679 MD 68 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Balto MD Essex 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 21221 1119 Punjab Drive U S Α death . Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itel mortant: if Item 27 is marked other than "natural", or Itel any injury or other treumatic event, the Madical Examinations. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Dennis Chaffman Lydia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia Hammonds-Daughter 556 Chalcot Sq Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 2-16-2010 Baltimore, MD Greenmount March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & Lady Balto, MD 21202 W 1101 E. North Avenue an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 Wes diac **Physician** /Medical Due to (or as a consequence of) Examiner Known Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physiclen and s the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical the use as attending I for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by alisades 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitei or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28b. Time of Injury 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 1 Natural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Dire 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

7. 709.

0-21221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 505^{а м} Physician/ Mattie Thomas Hazelwood 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Balto Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Days Min Hours 1 □ M 2 👽 F 77 Director 217-26-2068 S.C Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 XYes 2 ☐ No MID Baltimore na 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 33rd Street 1020 E. Apt 307 21218 should be filed within 72 hours after death 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. ò 1 Never Married 2 Married 1 Yes !! If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) IIth grade College (1-4 or 5+ Loudon Fog Seamtress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mattie Littlejohn Robert Thomas other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Thomas - Son 102 W. North Avenue Balto, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot emetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 2-27-2010 Randallstown, MD March East 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 700 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pilysicial/ Year disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine Due to for as a consiquence of cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 attending p IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Box (Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ns certificate has been signed I director, page 2 should be det by 1 Yes 2 Ko 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?
1 Yes 2 No performe 1 ☐ Yes 2 ☐ N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence ဂ္ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of De th 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No М Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of codifier

State Registrar 31. Date filed (Month, Day, Year)

FEB

24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death all 1 Month 1 EBRUARY Physician/ Linda 10: 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON MEDICAL BURNIE PLEN If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Hours 0770471943 Marvland 217 40 7720 66 Director Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21060 7885 Gordon Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Yes 2X No Yes, Give HALL, LINDA 1/N Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ASSEMBLY LINE - Retired Harte Hanks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Raymond E. Myers Page 1 and 2 should be (not available) Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan W. Hall / Brother 7049 Cresthaven Drive Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State Baltimore, Maryland 02/24/2010 4 Donation 5 Other (Specify) Bavview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List faily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ ongesti disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the burla Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No cate has been signed by the atte page 2 should be detached for 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Confirming Nurse Prantiener: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and make ras stated. oth one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0063564 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cuter Medical Baltimore Washing

DHMH 17 Rev 7/2009

State Registrar 32 Registrar's Signature

MD 20161

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month \in . 519 AM HAGWOOD Medical 0.5 105 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GOODSAMARITAN HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1-726 62 Yrs. 1 M 2 M Hours (Month Day, Country) Director Usual Residence of Decedent fshov 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 28a-f ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21239 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married ö ģ Maryland 21215-0036 Hack 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, Department of Health and Mental H Important: If item 27 is marked any injury or ----ည 1edozia eet and Number or Rural Route Number, City or Town, State, rreston Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) e of Juneral Se 23a. Part 1. Enter the piecase, or complications that caused shock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) burial-1 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Tetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months
1 Yes 2 No Por the Hospital or Attending Physician: The law requires that the death Month Year Pregnant at time of death the detached 9 Unknown 9 Unknown P.O. þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🗆 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) J.M 01 0 nia Cr iled (Month, Da., Year) Registrar's Signature State Registrar

OHMH 17 Fish 7/9009

10-01019 Dorothy Hantz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

orotny Hantz	State of Maryland / Department of Hea 1. For State Registrar Certificate of Dea		e 2010	05288				
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)	Mont	of Death	3. Time of Death 0937 hrs				
)		, Town, or Location of Death imore	4c. County of Death					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un $2 \mathbb{Z} = 55$ Yrs.		te of Birth (MM/DD/YYYY) 9/Birth Foreign Cour	011				
, we way	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
Aaryland 28a-f show: 1 at once. ector	Md. NA Baltima	re		1 Yes 2 No				
th the Maryland 23a or 28a-f sho notified at once.	5013 Pembridge Ave.	2/2/5	10g. Citizen of What Country USA	ry?				
or items 23		dent of Hispanic Origin? (Specify Ye cify Cuban, Mexican, Puerto Rican, e		an Indian, Black,				
ural", o	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 No specify:	Specify: Bla	dustry				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she unsatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		orking life. DO NOT use retired)	t. Med	lical				
ID 21215-0036 should be filed within 72 and Mental Hygiene. 7.7 is marked other than "17 is marked other than Taric event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) John Thomas Hantz Sr.	18. Mother's Deme (First, M	hiddle, Maiden Surname)	-< On				
nore, MD 213 gags 1 and 2 should b nt of Health and Men t: If item 27 is mar other traumatic eve TO E		(Street and Number or Rural Rou	ute Number, City or Town, State, 2					
Healt item	20a. Method of Disposition 20b. Place of Disposition (National Section 2) Removal from State crematory or other place	٥١ - ١	20c. Location - City or To	Nd. 21218 own, State				
Baltimore, permit. Pages 1 a Department of Department of He Important: If He Important: of He Important of He	4 Donation 5 Other Specify: Mt. Zion	2-27-10	Balto.	Md.				
Baltimo permit. Pag Department Important: injury or ot	21. Signature of Funeral Service Licensee 22. Name an Joseph 27. Natelle 4 / Harris A / 127.75	d Address of Facility L. Russ Funer W. North Ave.	al Home, P.A. 2	1216				
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	e of dying, such as cardiac or respirat	tory arrest, shock, or heart	Approximate Interval Between Onset and Death				
Examiner	Immediate Cause (Final disease or condition resulting in death) a Hypertensive cardiovasc Due to (or as a consequence of):	ular disease		503.11				
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
Fed nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
60, ate be execut hysician and e burial - tra	X UNPENDED AMENDED 20a,b per fh g900 23a,PII,27,perME,	2–25–10 vt G900 2/25/10 TT						
x 68760, h certificate be tending physic use as the bur ician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1 live birth 23c. If yes, outcome of pregnancy		23d. Date of delivery Month Da	y Year				
Records, P.O. Box 68760, The law requires that the death certificate be executed age 2 should be detached for use as the burial - trans completed by Physician/Medical E	past 12 months? 4 Pregnant at time of death 5 Other (Sp	ecify)						
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rds, require been signated	Diddeed Megazeee,			psy findings available impletion of cause of				
L ' = = [()		1 🗸	performed? death? Yes 2 No 1 ✓ Yes	2 No				
/ital ysicians nis certif director	25. Was case referred to medical examiner? 1 Yes 2 No	26.Place of Death (Check only one) DOA Other Nursing Home						
n of Vi ding Physi After this funeral di	27. Manner of Death 28a Date of Injury 28b Time of Injury (Month, Day, Year)	l <u></u>	scribe how injury occurred					
Division and or Attents after derivation led in by the extent led in by the extification artification.	2 Accident special in the stigation investigation and special investig							
To the Hospital within 24 hours To the Functial completely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in m							
To viri	and manner stated 29b. Signature and title of certifier 29b. Signature and title of certifier	Oc. License number	29d. Date signed (Month	n, Day, Year)				
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	February 5, 2010					
Drug	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2120	01					
State	31. Date filed (Month, Day Year) 32. Registrar's Signature			-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2010 Harris 20 EBR UMRY /Medical Eacility Name (If not institution, give street and number) 4c. County of Death Examiner BALTMORE AGNES If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕶 F Months 579-40-3000 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Nes 2 No Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21229 Brisbane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Blac 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If Item 27 is marked other than any Injury or other trainmatic mental for the many Injury or other mental for the many Injury or other trainmatic mental for the ma Elementary/Secondary (0-12) College (1-4or 5+) ro bore 17. Father's Name (First, Middle, Last, Be Ohnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grand Daughter 20a. Method of Disposition Burial 2 Cremation 3 F 3 Removal from State 21. Signature of Funeral Service License 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YOCARDIAL **Physician** MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Hospital or Attending Physician; The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 2 No Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier DU051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARLES 900 CATON AVE CURTIS ST. AGNES HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 24 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:47 PM 2 SAMUEL SIDNEY HERMAN FEB 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 0ctober 29, 1917 Massachusetts If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 M 2□ 032-07-6728 92 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. In Department of Health and Mantal Hygiene Informative it fems 23a or 28a-f show Important: If item 7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, he Marcical Examiner mast be notified at 1 □Yes 2 No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4705 Chevy Chase Blvd. 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1949–1959 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Public Elementary/Secondary (0-12) College (1-4or 5+) Health Service Commissioned Officer 5+ ges 1 and 2 should be filed vit of Health and Mental Hygic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Levitt Jacob Herman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 844 Elkins Avenue, Elkins Park, Pennsylvania 19027 Helen Shulik/Power of Attorney Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 21 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland Montgomery Crematorium, Inc Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition PNEUMONIA /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate En Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician a s the burial-1 Box 68760 Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2X No Division of Vital 1 XYes 2 □ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Matural 2 Accident (Month, Day, Year) Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and titlen certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 0101246064 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 PETER Z. MCINTYRE MC USN 31. Date filed (Month, Day, Year) legistrar's Signatur State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 20 2010 FREDERICK EARL HOLLAND 12:26 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER BALTIMORE TOWSON 5. Social Security Number Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Months Days Hours Min 212-28-0014 Yrs Director MARYT.AND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1903 WILDWOOD AVENUE 21234 USA 12. Was Decedent Ever in U.S. vvas Decedent Ever in U.S. Armed Forces? 1/1 Yes 2 D No if Yes, Give 1952-1953 Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE COUNTY YEARS POLICE OFFICER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 FRANK HOLLAND HELEN BEARES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHONDA HUGHES/DAUGHTER 14101 SCOFIELD RD. NE FLINTSTONE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
DULANEY VALLEY MEM. 4 Donation 5 Other (Specify) 2/26/2010 COCKEYSVILLE. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ve. Etiysician/ disease or condition resulting in death) ROS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No the g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed been si should l 24a. Was an . Were autopsy findings available prior to completion of cause of has page 2 s autopsy perform death? this certificate 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2/ No HOSNin ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural (Month, Day, Year) 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

to convows in

tlennaw:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

6701

29c. License number

29d. Date signed (Month, Day, Year)

2/21

110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 Drugry 24, 2010
Ac. County of Depth **Physician** ,201c William Louis Herman /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner es MS Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1**X** M 2□ F 87 3/6/1922 Maryland Director 219-07-5616 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mental Hyglene. The treath or Items 23a or 28a-f show ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, he "Modical Experience rust be rullined. 1 ☐ Yes 2 ▼ No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 713 Maiden Choice Ln, Bldg.1 USA 21228 Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X1Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No White Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 0 Railroad Rate Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Balster Herman Ileene Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn B. Herman/ Wife 713 Maiden Choice LN, Bldg 1, 1305, 21228 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any Injury or conce. Ownings Mill, Maryland MD. Veterans Cemetery 3/5/2010 21. Sc nature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** 50 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □ Yes 1 □Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be this c Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: , 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours af e Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature a

30. Name and addr

(Month, Day, Year) 31. Date filed FEB 2 4 2010

of person who completed cause of death (Item 23a) (Type, Print)

within 2 To the I

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 400 Michae a wrence 10 Medical 02 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomer Montgomery Kockville 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 - F Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Silver 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 20905 and 2 should be filed within 72 hours after death Health and Mental Hygiene. tem 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educational Advancement Elementary/Seconday (0-12) College (1-4 or 5+) Director of +6 Be 17. Father's Name (First, Middle, Last) Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any Injury or other trau Hamm Spring MD Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) tarklawn 21. Signatur of Funeral Service Licensee Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician etastati Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 signed by the attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Junknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending within 24 hours after death To the Funeral Director, A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier Kouertchou D63748

State Registrar J. Konatchon,

32. Registrar's Sig

Muncaster Mill Rd. Rockville,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 05294 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 21 2010 ROSE HANDLER 04:31P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GLEN BURNIE MARLEY NECK HEALTH & REHABILITATION ANNE ARUNDEL Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. 0872371921 Director 215-16-7897 88 Yrs. MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD ANNE ARUNDEL GLEN BURNIE 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7575 EAST HOWARD ROAD 21060 items . Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married 9 þ 1 Yes If Yes, Give Maryland 21215-0036 72 hours after 1 Tes 2 No Specify: Specify: WHITE "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **EXAMINER** CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HANDLER ABRAHAM SARAH CURTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEULAH BEW / SISTER 7466 E. FURNACE BRANCH RD., #208, GLEN BURNIE 21060 Baltimore, 20b. Place of Disposition (Name of OHE meters/Acte Oatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State any injury or 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ISRAEL CONG. 2/23/2010 BALTIMORE, MD Funeral Se 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature (030 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) OTIC CARDIOVASCULAR

BUSEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -trar that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 mg Month Pregnant at time of death detached 9 Unknown 9 Unknown P.O. ģ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, Completed 1 Yes 3 Probably 4 Unknown 245. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 No 1 Yes **Division of Vital** 25. Was case referred to edica director, Be 26. Place of Death (Check only one) examiner? မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann 28a. Date of injury of Death Certificate: 28b Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural (Month, Day, Year) 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

in (Item 23a) (Type, Pyint)

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			Registrar	Certific	ate of	Death		Reg. No.	1.0.0	
Med	Physici ical Exam		Decedent's Name (First, Middle,Last) DODEDT AT	mence tounco		D	2. Date of De Month February		Year	3. Time of Death 1544 hrs
/#***.T. **			4a. Facility Name (if not institution, give s	VRENCE JOHNSON treet and number)		K。 b. City, Town, or Location of			010 c. County of Death	
			230 Wanda Road	,		Pasadena	, Death		Anne Arundel	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday)	If Under 1 Year If Unde	r 24Hrs. 8. Date of I	Birth(MM	/DD/YYYY) 9. Birt	hplace (State or
	Director		220 60 9727 1XM	2□F 53	Yrs.	Months Days Hours	Min. 11/1	18/1	956 Cou	n untry) MD
			Usual Residence of Decedent			I		10/1	750	
	w any		10a. State 10b. County	10c. City, Town	or Locatio	'n				10d Inside City Limits
	ith the Maryland 23a or 28a-f show notified at once.	to	MD Anne Ar	undel		Pasaden	a			1 Yes 2 No
0	e Mar or 28a	Director	10e. Street and Number			10f. Zip Code		10g. Citi	izen of What Coun	try?
ñ	ith the 23a c		230 Wanda		40.00	21122			U.S.A	
0	ath w items	Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of Hispanic Orig s, specify Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	No-	 Race - America White, etc. 	an Indian, Black,
/	fter de ", or er m	F	3 Widowed 4 Divorced If	Yes 2 No Yes, Give Year	1 ,	Yes 2 No specify:			Specify: 1.7h	
	ours a atura	d by	15. Decedent's Education (Specify only	Dates: highest grade completed) 16a. [Decedent's	s Usual Occupation (Give k	ind of work done	16b. I	Kind of Business/Ir	ite ndustry
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	212 Jld be Menta mark	0 B	Robert Lawren 19a. Informant's Name/Relationship (Type	ce Johnson, Sr	Mailing	Ja Address (Street and Numl	ne Ellen	Cla	tchey	7:- 0-1-)
	IMOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene in the Maryland in the Arman I filem 27 is marked ofter than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.									
	ore, ML es 1 and 2 s of Health a If item 27 her traum	ı	JoAnn Sien / Si 20a Method of Disposition	20b. Place o	f Dispositi	rley Neck	Date	20c.	Location - City or 1	MD ZIIZZ Fown, State
	nor ages at of it: If		1 Burial 2 Cremation 3	Removal from State cremato	ory or othe	er place)		ı		
:		- 1	4 Donation 5 Other Specify: 21. Signature of Edneral Service Licenses	Bayvi	ew C1	rematory (me and Address of Facility	$\frac{02/20/10}{6}$		Baltimo	re. MD
- 1	Balt permit Depart Import injury	I	The same		1169	9 Riviera 1	G.J.GON	ce i	dunerai Mena M	ноте, РА D 21122
	Physician		23a Paryl. Enter the disease, or complicate failure. List only one cause on each	tions that caused the death. Do no	t enter the	mode of dying, such as ca	rdiac or respiratory a	rrest, sho	ock, or heart	Approximate Interval
	/Medical Examiner	1	Immediate Cause (Final disease a. I	idocaine intoxi	catio	on				Between Onset and Death
		ı		e to (or as a consequence of):						
		<u>.</u>	Sequentially list conditions. b if any, leading to immediate Due	e to (or as a consequence of):						
Ą		xaminer	cause. Enter Underlying Cause (Disease or injury that initiated	, to (o) as a solitorial (i).						
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9	e be e	ğ		MENDED 23a,27,28a	-f,pe	rm,E g901 3/	11/10 TT			
Ì	tificat ng ph as the	<u> </u>	3b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy Live birth	Fetal	death 3 Ectopic	pregnancy	230	 Date of delivery Month Date 	ay Year
(ath cel	18	1 Ves 2 No 0 Hakagun	Pregnant at time of death 5		r (Specify)				,
	be de	Physician/Medical		Unknown						
(that the detac	<u>\$</u>	Part II. Other significant conditions co	ntributing to death but not resulting	in the und	derlying cause given in Parl			use contribute to th	ne cause of death?
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3	Phys er this	유	1 ✓ Yes 2 No 27 Manner of Death	I Inpatient 2 ER/Ou	tpatient :		Nursing Home 5		nce 6 🗸 Other:	Scene
	nding th. th. e fune	<u>ië</u>	1 Natural 5 Pending	(Month, Day,Year)	•	iry 28c. Injury at Work?	1	-	ryoccurred gested di	7110
	DIVISION Of VITAL RECORDS, P.O. BOX 88/50, 10 of a Attending Physician: The law requires that the death certificate b rs after death. al Director: After this certificate has been signed by the attending physicled in by the funeral director, page 2 should be detached for use as the but	icat	2 Accident Investigation	2/17/10 unk 28e. Place of Injury - At home, far					_	
č	ital or ral Di	Certification:	3 X Suicide 6 Could not be determined	(Specify) home	, 5.1561,	.aa.a,, omeo bunding, etc.	or Town, Pasade	State) 2	Wanda	Route Number, City Ave
	LIVISION OF VIXIL RECORDS, P.O. BOX 68 / 60, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - tran		20s Continue	To the best of my knowledge, deat	h occurre	d at the time, date and plac				
	o the	Medical	one) 2 Medical Examiner: On	the basis of examination and/or in-	vestigation	n, in my opinion, death occu	urred at the time, date	and place	ce, and due to the	cause(s)
	E 2 F 2	ž	29b. Signatule and title of certifier			29c. License number		29d F	ate signed (Mont	h Day Voorl

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State 31. Date filed (Month, Day, Year)
Registrar FFB 9 4 2010

32. Registrar's Signature

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

February 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 31, 2010 8:32P James Walter Kelly Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1135 Ocean Parkway Bldg 3 #214 Ocean Pines Worcester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ★M 2 □ F Hours Min 04-30-1922 WASHINGTON, DC Director 577-22-2613 10a. State 10b County 10d. Inside City Limits 28a-f shov 10c. City, Town or Location death with the Maryland Director the Medical Examiner must be notified Worcester 1 X Yes 2 □ No Ocean Pines MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1135 Ocean Parkway Bldg 3 #214 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian rmed Forces?

X Yes 2 \(\subseteq \) No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE DRIVER Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other 18. Mother's Name (First, Middle, Maiden Surname) 2 ALBERTA JONES CHARLES FRANK KELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 SAVANNAH ST SE WASHINGTON, DC 20032 JAMES W. KELLY JR/SON 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2-16-2010 CHELTENHAM, MD MD VETERANS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC PROSTATE CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to jor as a consequence of Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death Yes 2 X No Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pertormed 2 🗌 No 1 Yes Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2/15/2010 D63424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RACETRACK ROAD BERLIN, MD 21811 MD MUNNA GARG. 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Shirley Ellen Koehne February 2010 22, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Long View Nursing Home Manchester Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 M 20XF 78 Director June 21, Maryland 215-28-7715 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 XXIO Director Maryland Baltimore Upperco with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō United States items 23a Funeral 15429 Dover Road 21155 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23s any injury or other traumatic event, the Medical Examiner must once. America 14. Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes XX No Specify: Specify: White þ 3√XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bendix Field Elementary/Secondary (0-12) College (1-4or 5+) llth Engineering Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura V. Griffith Andrew Guy Naylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Leidner (Daughter) 2718 Hi-View Drive, Hampstead, Maryland 21074 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or of Pleasant Grove XXBurial 2 Cremation 3 Removal from State Feb. 26, 4 Donation 5 Dother (Specify) 2010 U.M.C. Cemetery Reisterstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityEckhardt Funeral Chapel, P.A. Ball & 3296 Charmil Drive, Manchester, Maryland 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 uns /Medical ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed exportan Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 | Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear 4□Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ¥ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.7 No certificate 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Tol 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 1 Natural 2 ☐ Accident 5 Pending Injury 1 □ Yes 2 □ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

2

Date filed (Month, Day, Year) State FEB 24 2010 Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State	of Maryla		artment of H		Mental Hyg	giene	1.0	05000
		State Registrar			Cei	tificate of E	Death	,	Reg. No ZU	IU	05298
Physic	cian/ dical	1. Decedent's Name (First, Mid		seph	Henry	Kim		2. Date of Dea Month Februa	Day	Year 2010	3. Time of Death 5:54 P ^M
Exam				,		1	Location of Death		4c. County		
		7418 Old Ba	ttle Grove				dalk		 		ce Co.
Funera Directo		187-32 - 4610	1 M 2 □ F	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 2)	h (Year) (1941	Count	lace (State or Foreign ry) 1Sylvania
d ow t	٦.	Usual Residence of Decedent 10a, State 10b, Cou	nty	10- 0	ity, Town or Lo						
arylan a-fsh fied a	Director	MD 103. Soci	-3	106. 0	ity, Town or Lo		1 11			10	0d. Inside City Limits 1 Yes 2 No
or 28	ä	10e. Street and Number	Baltimore			10f. Zip Code	ndalk		10a. Citizen of V	What Count	
with is 23a	Funeral	7418 Old Bat	tle Grove	Road			21222		5	ed St	,
DaltIIMOre, IMBIYIBING Z1Z13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			Armed F	edent Ever in U orces?	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
al", or	ð A	1 Never Married 2X N 3 Widowed 4 Divor	If You G	2 🚺 No ive		1 ☐ Yes 2X No			Specify:		White
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ary hould and M is mai		19a. Informant's Name/Relation			19b. Mailir	ng Address (Street a	and Number or Rur	al Route Number	; City or Town, S	State, Zip C	ode)
nd 2 s ealth m 27		Marilyn M. K	im (Wife)	7418	Old Batt	le Grove	Road D	undalk,	MD	21222
Dalumore, bermit. Page 1 and Department of Hea mportant: If item		20a. Method of Disposition 1 Burial 2 Cremati		n State	cemetery, crer	sition (Name of natory or other place	e) !	Date	20c. Location -	•	· —
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Medica Examine		resulting in death)	Due to	(or as a consec	quence of):						7-2-
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rate be executed physician and the burial-transit	12日日	resulting in death) Last	Due to	(or as a consec	quence of):						
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certific	J/N	IF FEMALE: 23b. Was decedent pregnant		atcome of pregn		Ectopic pregnanc			23d. Dat	te of delive	ry
death of the atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of		Other (specify)	y 		Мо	nth I	Day Year
at the			litions contributing to	death but not re	sulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contr	ribute to the	e cause of death?
J. Lires th	Completed by	Liver F	ailure								ably 4 🗆 Unknown
e law require has been sig ge 2 should b	plet	.						24a. Was a			sy findings available npletion of cause of
The Is zate his page	S							autop perfoi 1 Yes	rmed?	death?	
vsician: s certific	Be	25. Was case referred to medic examiner?	dal Hospital: _				ace of Death (Chec	k only one)			
Phys Phys r this eral dir	욛	1 Yes 2 No	1 [28a. Date	Inpatient 2	ER/Outpatier 28b. Time of		4 U Nursing H	ome 5 Resid	ence 6 Othe		
inding ath. r: Afte	icate	Natural 5 Per 2 Accident Inve	/3.4	nth, Day, Year)	injury	work'	? Yes 2 □ No	Zod. Bescribe in	ow rijury occurre	50	
or Attending Porter death. irector: After to by the funera	Certificate:	3 Suicide 6 Cou	uld not be ermined 28e. Plac build	e of Injury - At h ling, etc. (Specit	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number	er or Rural I	Route Number,
pital of purs all eral D											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical only one) 3 Certify	ring Physician: To the al Examiner: On the ba ring Nurse Practioner:	asis of examination	on and/or invest	tigation, in my opinio	n, death occurred a	at the time, date a	nd place, and due	e to the caus	se(s) and manner stated.
To the To the Contract of the	-	29b. Signature and title of cert	iner)		29c. License	number		29d. Date signed		
		30. Name and address of pers	<u> </u>		00-1 7	1 1 1 1 4	4716		5(53)	201	0
		Name and address of pers	on who completed cau	eet C	3a),(Type, F	ont)	0212	3/			
St Regis	tate trar	31. Date filed (Month, Day, Yea	2010 Series	Registrar's Sig	ature park						

			1 = For State Registrar	State of Marylar		artment of H			giene	0 05299
4	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Robert As Essilib Name (Hast institution in the state of the state o	N	Ku	rland		2. Date of Dea Month February	th Day Ye	3. Time of Death
5	Examir	ner	4a. Facility Name (If not institution, give street The Johns Hopkins Hos			4b. City, Town, or Baltimore		th ·	4c. County of E	N/A
, .	Funeral Director		213-52-6919	7. Age (In yrs.	last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		Year) 9. 1955	Birthplace (State or Foreign Country) MD
	death with the Maryland ems 23a or 28a-f show must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE		ty, Town or Loc	1				10d. Inside City Limits 1 ☐ Yes 2 💢 No
	th with 23a or st be n		10e. Street and Number 54 NORTHWOOD DRIVE			10f. Zip-Code 21093		1	0g. Citizen of What	Country?
5-0036	ours after al", or ite Examiner	by Funeral	11. Marital Status 12. 1 Never Married 2 X Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, /hite, etc.
)-CLZL;	s 1 and 2 should be fled within 72 hours after of Health and Memtal Hygiene. The Table 1 is marked other than "natural", or its other traumatic event, the Medical Examine.	Completed	15. Decedent's Educa (Specify only highest grade c Elementary/Secondary (0-12)		(Give I	ent's Usual Occupa kind of work done o PO NOT use retired) PROGRA	luring most of wo	orking	16b. Kind of Busine	
land	be filed tal Hygi d other event, t	Be C	17. Father's Name (First, Middle, Last)			T NOGIVI	18. Mother's Na	ame (First, Middle,		
aryla	2 should b and Menta is marked raumatic ev	6	A. SAMUEL KURLAND 19a. Informant's Name/Relationship (Type.	Print)	19b. Mailin	g Address (Street a	GLORIA and Number or F		r, City or Town, Stat	FISHMAN e. Zip Code)
	1 and 2 Health a em 27 is ther trau		CHARLENE KURLAND /		54	NORTHWOO		, TIMONIU	M, MD 210	93
E OE	Pages 1 nent of F nt: If ite iry or ot		20a. Method of Disposition 1	oval from State	emetery, crem	sition (Name of eatory or other place SINAI	· .		20c. Location - City OWINGS M	
Dallimor	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licensee	/	22	Name and Addres	s of Facility S(DL LEVINS	ON & BROS	., INC.
	4 B Z % O		23 art 1. Enter the disease, on licat shock, or heart failure. List only one c	ions that caused lie death	n. Do not ente	r the mode of dying	ERSTOWN g, such as cardia	ROAD, PI ac or respiratory arr	KESVILLE,	MD 21208 Approximate
>	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	uence of):	11 lun	g car	ncer		Interval Between Onset and Death
,00,	sate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
O. DOX 001	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnat 1 Live birth 2 Feta 4 Pregnant at time of do	I death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	w requires that the search of the signed by the should be deta	ρχ	Part II. Other significant conditions contrib	outing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tot		e to the cause of death?
מו וופכס	ate has bee page 2 sho	Completed						24a. Was ar autops perforn 1 Yes	y prior ned? death	autopsy findings available to completion of cause of 1? Yes 2 \sum No
A	ysician s certific directol	To Be	25. Was case referred to medical examiner? 1 \sum Yes 2'10 No Hos	pital: 1 ☑ Inpatient 2 □	ER/Outpatient	Other		ath <i>(Check only one</i> Iome 5 \square Reside		pecify)
O HOLDING	To use mobile of when the properties within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page	ertification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At ho building, etc. (Specify	28b. Time of Injury			28d. Describe ho	w injury occurred	Rural Route Number,
Hoenkal or	24 hours after Funeral Directory filled in	edical Cer	29a. Certifier 1 X CertifyIng Physicia	an: To the best of my know: On the basis of examinat and manner stated.	vledge, death	occurred at the time	e, date and place inion, death occ	e, and due to the caurred at the time, d	ause(s) and manner	as stated. due to the cause(s)
To the	within To the comple	Mec	29b. Signature and title of certifier M. [29c. License i	number 3.748		ed. Date signed (Mo	
			30. Name and address of person who comp RAJANI JAGANA 31. Date filed (Month, Day, Year)							nore, MD, 21287
	Stat	(2)	on Jako mod (monut, Day, real)	32. Registrar's Signatu	Section of the last of the las	Per				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GA RRETT Year Month **Physician** 0650AM LEONARD LIGHT FOOT 2010 FEB 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/ABaltimore John Hopkins Hospital 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) 3 3 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 76 Director 063-30-0704 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Columbia Baltimore Co. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 U.S.A. 5495 Cedar Lane Apt.611 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【XNo 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □Xo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Midowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, Ite I Poles once. Elementary/Secondary (0-12) College (1-4or 5+) Printing Co. Silk Screen Printer 11th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lightfoot Elizabeth ပ Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1917 Eastwest Hwy Apt.T2, Silver spring, MD 19a. Informant's Name/Relationship (Type. Print) Eugene Lightfoot(Son) 20b. Place of Disposition (Name of Constant Commerce) Commerce of Marcel Hopkins U. M. Marcel Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 02/27/10 | Highland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 iamo retich 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner Monety SEVERE COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Menters requires that the death certificate be executed DYSPHACIA physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as f IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 sl performed? Yes 2 No this certificate 1 ☐Yes 2☐No 1 □Yes of Vital To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № ☐ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

Shakun male 31. Date filed (Month, Day, Year) FEB 24 2010

Sholun note

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suple MD

32. Registrar's Signature

29c. License number

9650 Santago Rd Sute 110

D0023110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Pex FH C900 2/26/2010 JH Department of Health and Mental Hygiene 2 U U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rudolph Ludwig Linde Feb 19, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville 725 Streaker Rd 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Min. 86 MD Director Apr 17, 1923 216-14-7902 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 No Sykesville MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ♣No Specify. Completed 3 Widowed 4 Divorced Year or Dates 1/8/1946 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) **Business Owner** Service Station Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Wilhemina Elizabeth Wendeler John Wilhelm Linde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Streaker Rd. Sykesville, MD 21784 Kathleen Linde Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Feb 25, 2010 Catonsville, MD Baltimore National Cemetery 22. Name and Address of Facility Service LI Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure List only one cause on each line. Approximate Interval Between t and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-tran and that initiated events resulting in death) Last Due to or as a consequence of within 24 hours after death.

To the Funeral Director: After this certificath has been signed by the attending physician is completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Tes 24b. Were autopsy findings available 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: မ 1 Tyes 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 \square Pending 1 Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier d. Date signed (Month, Dav. Year)

State Registrar

30. Name and address of p

31. Date filed (Month, Day, Year)

110

of death (Item 23a) (Type, Print)

10-01413 Gregory Long Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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			- For State Registrar				Certifica	ate of	t Death)			R	eg. No.		
	Physicia	ın/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year February 16, 2010 1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last)													
	'ical Exami		Gregory Dwy	ane	Long								February			
			4a. Facility Name (if not institution		street and n	umber)			4b. City, To		ocation of	Death		- 1	County of Dea	
			7525 Buchanan Stree						Hyatts		Ich I dan	0.41.1	9 Data of Bi			Birthplace (State or
	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last birtl	hday)	If Unde Months		If Under Hours	Min.			Fore	country Carolin
	Director		245-45-4880	1X	M 2 F		39	Yrs	s.				Dec.	1/,	1970	Carolin
	b	-	Usual Residence of Decedent 10a. State 10b. County			100	City, Town	or Local	tion							10d. Inside City Limits
	ом апу				Coor		Hyatt									1 Yes 2 X No
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)	ith the 23a c notifi		7525 Buchana		12. Was De		rinIIS	13 W			anic Origi	n? (Spe	cify Yes or No			erican Indian, Black,
1	ath w	Funeral	1 Never Married 2 N		Armed F	orces?			res, specify						White, etc.	
	ter de			orced 1	1 Yes If Yes, Give Ye	2 X	No	1	Yes 2	Z No	specify:				Specify: B1	ack
	urs af tural	ğ	15. Decedent's Education (Spe		or Dates:			Decede	nt's Usual (Occupatio	n (Give ki			16b. h	(ind of Busines	s/Industry
	72 hor	Completed	Elementary/Secondary (0-12)		College (1-4 or 5+)			nost of worl	_			a)	U.	S.Gov	ernment
	036 ithin and the control of the con	d d				3	Da	ata	Base						<u>entago</u>	n
	5-0-8-1 led w		17. Father's Name (First, Middle										First, Middle,			
	21 be fi ental l arked	B	James Stephe				1.00						th Co		ity or Town, Sta	ato Zin Code\
	D 2 hould and M is ma	2	19a. Informant's Name/Relation													N.C.27231
	MC and 2 s alth a sm 27		Katrina Long	Al	brigi	nt T	20b. Place of						Date Date		Location - City	
	of He		1 X Burial 2 Cremation	n 3 [Removal	from State	cremat	ory or o	ther place)				04 44			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injury or other traumatic event, the Medical Examiner must be notified at once.	Ш	4 Donation 5 Other S	pecify:			Lee':		apel Name and							rove, N.C.
	Salt Separi Mapor njury		21. Signature of Funeral Service		7.4							Maı	czullo	ς Fι	uneral	Chapel, P.
			Muchael P. M. 23a. Part I. Enter the disease, o	ary.	cations that	caused the	death. Do no	ot enter	() () 9 H . the mode o	arfo of dying, s	uch as ca	Roar rdiac or	re piratory ar	rest, sho	ock, or heart	Approximate Interval
	Physician /Medical		failure. List only one cause	on eac	n line.											Between Onset and Death
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	760, ficate be g physic t the bur	Mec	IF FEMALE:	ile e	23c. If yes	, outcome o	f pregnancy							23	d. Date of deliv	
	687 certifications de as t	sician	23b. Was decedent pregnant in past 12 months?	ii le	1 Live	birth Inant at time	of death				Ectopic	pregnan	су		Month	Day Year
	Box 68 e death certil the attending ed for use as	sic	1 Yes 2 No 9 U	nknown		nown		•	ther (Spec	, my)						
	P,O. Box 687 s that the death certific gned by the attending p e detached for use as th	Phy	Part II. Other significant cond	tions	contributing	to death bu	t not resultin	g in the	underlying	cause gi	ven in Par	t I.				to the cause of death?
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	of Viring Physical After this	-	27. Manner of Death		28a. Dat	e of Injury th, Day,Year)	28b.	Time of	f Injury :	28c. Injur	y at Work	?	28d. Describe	how inj	ury occurred	
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	IVISION or Attence after death Director:	lic3		uld not b	28e Pla	ace of Injury	- At home, f	arm, str	eet, factory	, office bu	uilding, etc	c. :	28f. Location or Town,		and Number or	Rural Route Number, City
	Divis Hospital or A 24 hours after Funeral Dire	Certification:	4 Homicide det	ermined	1											
	Hosp 24 hc Fun etely		(Oncon only)	Physicia	an: To the b	est of my kn	nowledge, de	ath occ	urred at the	time, da	te and pla	ce, and	due to the car	use(s) ar	nd manner as s ace, and due to	tated
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	S Regis	tate	31. Date filed (Month, Day, Yea	2010	1	Registrar's	Signature	par	Kar							
	Kegis	47121	1 10 10 10 1		100.										001	ME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Robert B. A. Licciardo IB. 2010 A^{M} 8:32 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5849 Genesis Lane Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days Min. 1 X M 2 D F 552-86-3773 **Director** ustralia November 1 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 United States 5849 Genesis Lane 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ |Federal Government Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Concetta Natoli Antonio Licciardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Tomar Court, Cheltenham, Victoria, 3192 Australia Mary Angela Licciardo/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 26, cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 2010 Washington, D.C. 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Years Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 perform this certificate 2 No Yes 2X No 1 Yes **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Assisted 2 XNo Hospital Other: 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number D22101 February 19, 2010 npleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Lloyd Halvorson,
31. Date filed (Month, Day, Year)

32. Regis rar's Signature

1475 Taney Avenue, Frederick, Maryland 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010 05304										
ı	Physicia		1. Decedent's Name (First, Middle, Last)	Margaret	May	Louk		2. Date of Dea Month Feb	Day Year	3. Time of Death 10 6:00 A ^M		
~	Medic Examin		4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, or	Location of Death	1.00	4c. County of De			
	,		1925 Nevill Road			Du If Under 1 Year	nda1k If Under 24 Hrs.	La 5		more Co.		
	Funeral Director		5. Social Security Number 6. Sex 1 \square	M 2 🔀 F 72	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day April	Year) 10,1937 We	irthplace (State or Foreign lountry) St Virginia		
	how how	ŗ	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits		
	Aarylar 8a-f s tiffied	recto	MD Balt	timore			Dundalk	:		1 ☐ Yes 2 🔯 No		
	a or 2 be no	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0			
	ms 23 must	ner	1925 Nevill Road	2. Was Decedent Ever i	0116 13 1	Was Decedent of His	21222	ocify Yes or No-	United St			
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	l	f Yes, specify Cubar	n, Mexican, Puerto	Mexican, Puerto Rican, etc.) Black, White, etc.				
2-0	2 hour "natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give I	ient's Usual Occupa		ing	16b. Kind of Busines	s industry		
121	ithin 7 ene. r than the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)		o NOT use retired) okkeeper		Printing Co.				
pd 2	al Hygi I othe vent,	Be	17. Father's Name (First, Middle, Last)		1 200	1	18. Mother's Nam	e (First, Middle, I				
ylaı	Menta Menta narkec	잍	Fred Arbogast				Paul	Line Smi	th			
Maryland 21215-0036	2 shouth and the and 27 is not traum.		19a. Informant's Name/Relationship (Type Mr. Eli W. Louk (ng Address (Street a 5 Nevill :		ai Route Number ndalk, M	; City or Town, State, 2 laryland 2	Zip Code) 21222		
re,	1 and of Heal item		20a. Method of Disposition	21	0b. Place of Dispo	sition (Name of natory or other place		Date	20c. Location - City	or Town, State		
Baltimore,	Page ment tant: If		1 ♣ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Holly H	ill Mem.	Gdns. 2/	25/2010	Middle Ri	lver, MD		
Balt	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:		21. Signature of Funeral Service Lightsee			Name and Addres 1da-Ruck 1922 Wise			Dundalk, I Maryland	Inc. 21222		
П			23a art 1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the cause on each line.						Approximate Interval Between Onset and Death		
	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con		chogen	ic Ca	raNO.	MA	2 mon ths		
\mathbb{Z}	Examiner											
	d sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying									
	xecute n and al-trans	Exar	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a cor	sequence of):							
00	sate be executed physician and the burial-transit	edical	L _d									
3876	rtificat ing ph e as th	/Mec	IF FEMALE:	a litura autormo of pu		_						
Box 68760	ath ce attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pr 1 Live Birth 2 4 4 Pregnant at time 	Fetal death 3	Ectopic pregnanc Other (specify)	У		23d. Date of o Month	delivery Day Year		
Э.В	the de by the tached	hysi	9 🗆 Unknown	9 Unknown								
, P.O.	es thai signed I be de	by	Part II. Other significant conditions cont	1	1					to the cause of death? Probably 4 Unknown		
ord	requii been should	lete			-			24a. Was a		autopsy findings available		
Rec	The law ate has bage 2	Completed						autop perfor 1 🗌 Yes	rmed?// death	o completion of cause of ? 'es 2 No		
tal	cian: T	Be	25. Was case referred to medical examiner?	espital:		26. Pla	ace of Death (Chec					
of Vi	Physi r this c eral dir	6:	1 ☐ Yes 2 ☑ No ☐ 127. Manny of Death	1 Inpatient 28a. Date of injury	2 ER/Outpatier 28b. Time of	nt 3 □ DOA 28c. Injury	4 ☐ Nursing He		ence 6 Other (Special Objection)	ecify)		
ou o	ath. r: Afte	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	ar) injury	work	? Yes 2 ☐ No					
Division of Vital Records,	I or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sc		eet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical			nation and/or inves	tigation, in my opinio	n, death occurred a	t the time, date a	nd place, and due to th	e cause(s) and manner stated.		
	vithin To the	2	29b. Signature and title of certifier	/	or my knowledge,	29c. License	number		29d. Date signed (Mor			
	•		-	ender M.)		1846		2/19/1	21237		
			30. Name and address of person who cor Martin J. Sheridar	inpleted cause of death ${ m M.D.,F.A}$	(Item 23a) (Type, F . C . P . , F .	C.C.P. 90	000 Frank	lin Squa	are Drive	Baltimore, MD		
	Sta Registr		31. Date filed (Month, Day, Year) FFR 2 4 2010	32. Registrar's S	ignature	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY Physician/ 2010 Ам 4:15 LEVITT REVA H Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 5. Social Security Number **Funeral** 1 M 2 F Days Hours 6/22/1915 MD 218-01-2862 94 Yrs Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 况 No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 7133 PHEASANT CROSS DRIVE 21209 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation. 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BUSINESS OWNER ANTIQUE JEWELRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MINNIE HEYMAN LEON GOLDSMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7133 PHEASANT CROSS DRIVE, BALTIMORE, MD ANNAFAYE JOFFE/COUSIN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP CEM: 2/23/2010 BALTIMORE, MD 1 ☐ Benation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of F neral Se 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (r as a consequence of): Examiner nevmonin Sequentially list conditions, if any, leading to immediate Examiner he to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No Month Year Day 5 Other (specify) 4 Pregnant a Pregnant at time of death signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes ုဝ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after death Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title

State Registrar 31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Registrar's Signature

22

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #3, PI line a 23e per MD 9901 3/15/10 TT
State of Maryland Department of Heatin and Merital Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Time of Death Physician/ Month February 2010 JOANNE LEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE 8. Date of Birth (Month, Day, Year) DEC 15 1 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖔 F Months Hours Country) MARYLAND Director 65 214-44-7759 1944 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5682 ARNHEM RD 21206 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: BLACK 3 Widowed 4XXDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12th grade PROJECT MGR HOPKINS BAYVIEW 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ္ပ JOHN WALTER LEE AGENORA WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernetta Lee/Daughter 4872 Greencrest Rd., Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 02-26-10 BALTIMORE, MARYLAND 21. Signature American Solving 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 23a. Part Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lancer Physician Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 **X** No robably 4 🗆 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2 s 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 XVo 1 🗌 Yes ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After the Hospital or Attending injury Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical ᢏ rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Deog Hourani, 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6901 of Cornowi Charles 31. Date filed (Month, Day, Year) 32. Registrar's State FEB 2 4 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Feb. Day 2010 Physician/ URRA 20 :30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Bayview Medical</u> Baltimore 8. Date of Birth (Month, Day, Year) 9-10-1963 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 M 2 TXF Days 46 Director 220-90-2415 MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Dunshire Way, 7105 Apt. 21222 USA 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes 2 **X**O Baltimore, Maryland 21215-0036 1 Yes 2X No Specify If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Elementary/Seconday (0-12) College (1-4 or 5+) **LPN** <u>Medical</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Charles S. Murray Rosemary Weimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 Dunshire Way, Rosemary Murray - Mother A-3Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 26-10 Baltimore.MD Crematory 21. Signature of Funeral Service Licen 22. Name and Address of Facility Bradley-Ashton FUneral Home Spring Road 2134 Willow 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as, sequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conset that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached t 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗆 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No ၉ 1 Inpatient 2 KER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral in the fune 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homici**d**e determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 ALTIMORE. Road air

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. _ Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 8:42 DM Physician 4a. Facility Name, (If we institu /Medical 4c. County of Death 4b. City, Town, or Location of Death institution, give street and number) Examiner Kaven Timore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Hours 134-26-7541 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho 1 Tes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 212 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 ☐ No If Yes, Give Was Decedent of Hispanic Φrigin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 2 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4gr 5+) Elementary/Secondary (0-12) NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျ 11119 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) boune Rd. Son eto. moore IR Monzo 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 2010 OWING ravres injury 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licenses Approximate Interval Between Onset and Death 23a. P. r 1. Ent r pr disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, of heart failure. List only one cause unleach line. Immediate ause (Final disease * condition resulting in death) Known **Physician** Timar /Medical Due to (or as a col Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and the for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☑ Unknown 1 □ Yes 2 🗌 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 □ Yes 2 ☑ No certificate 2 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signe (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 20 e and address of person who completed cause of death (Item 23a) (Type, Print) Ohn 3900 Lock Miryd 32. gistr Signature 31. Date filed (Month, Day, Hegistrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eleanor Mathis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital i more ear If Under 24 Hrs. (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days Hours 1 □ M 2 🛣 F 11-19-Y 91 Director MD218-22-4952 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County be filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Baltimore na 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 1027 Chase Street Apt H 21202 U S A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3√2 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade <u>Cleaners</u> Presser Be 18. Mother's Name (First, Middle, Maiden Surname) မ Boise Matthews Helen Rimes if. Page 1 and 2 shour.
If Health and Mr.
If The Tism. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21225 Cardia Gamble-Friend 2831 Carver Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Mt Zion Cemetery 2-25-2010 Lansdown, 4 Donation 5 Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 13 la 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ner Due to or as a consiquence of: cause. Enter Underlying Cause (Disease or iinjury Exami that the death certificate be executed as the burial-tran been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of the IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed director, page 2 should 24b. Were autopsy findings available 24a, Was an autopsy performed? prior to completion of cause of death? has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 WHO Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the ! 3 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s S

Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G900, 2/24/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ Menth FEB 12Y LOUISA MAY McNEAL 2010 6:15AM ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Manchester 4509 Alesia~Lineboro Rd. 8. Date of Birth Jan . 28, 1911 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours Maryland 99 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director Baltimore County 1 🗆 Yes 2 ื No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 7827 Babikow Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 21215-0036 1 Yes 2 K No Specify: Specify: White Completed ¾ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 7th grade (0-12) Callege (1-4 or 5+) Homemaking-Own Home Homemaker Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Katherine Sapp John Henry Mohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 Orems Rd. Baltimore, Md. 21221 George J. McNeal, Jr. (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State 3~2~2010 Baltimore, Md. Zion Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. F. Las 21236 Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): artery Medical Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) g Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Siving Altic Stensus 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Acsidence 6 Other (Specify) Residence ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 24 hours after death. Funeral Director; A 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director; / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mD060005L 2-15-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 Joanne ChanMA Familye Hanover PA 17331 200 Ste 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

FEB 24

LouisA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4	1 = For State Registrar	State of Ma	arylan		artment of F <i>tificate of</i>				giene Reg. No	10	05311
Physician /Medical	1. Decedent's Name (First, Middle Eugenia	wille#e	Mi	11e/			2	2. Date of De Month	ath Day	2010	3. Time of Death 13:10 M
Examiner	4a. Facility Name (If not institution Chester Rive 5. Social Security Number	n, give street and number)		last birthday)	4b. City, Town, o Chester If Under 1 Year	town	1	B. Date of Bir	Ken	9. Birth	place (State or Foreign
Director	070-18-0039 Usual Residence of Decedent	1□ M ¾ □ F		9 Yrs.	Months Days	Hours		Oct. 27, 1920			York
or 28a-f show	10a. State 10b. County Maryland Ken	ıt		y, Town or Lo rton					10 000		0d. Inside City Limits 1 ☐ Yes 2 ▼ No
r items 23a irrer must. Funeral	10e. Street and Number 12058 Parson 11. Marital Status 1 Never Married 2 Marr	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	Ever in U.	1	10f. Zip Code 21678 Was Decedent of If Yes, specify Cub	dispanic Or an, Mexica Specify	n, Puerto Ri	ify Yes or No ican, etc.)	E		can Indian, etc.
ygiene. ner than "natural", o t, the Medical Exam Completed by	3 Widowed 4 Divorced 15. Deceden (Specify only higher Elementary/Secondary (0-12)	Ye ar or Dates:		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	durina mos	st of working	7		WN1 Business/in	
is marked other than aumatic event, the Me To Be Compl	17. Father's Name (First, Middle,	Last)		Tran	scriber			First, Middle,	Maiden Surr		ustr <u>y</u>
27 is marke er traumatic	William Mille 19a. Informant's Name/Relations Paul Kelsch				ng Address <i>(Street</i>	and Numb	er or Rural	Route Numb	er, City or To		o Code) land 21678
Important: If item 27 is any injury or other trau	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □ Removal from State	- 1	lace of Dispo emetery, cren ly Cr	sition (Name of natory or other place OSS Cem	eter	Dai y 3-1	te	20c. Location	on - City or To	own, State
Importa any inju	21. Signature of Funeral Service	marsullo		6(Name and Address	ess of Facili	Mar:	zullo Balti	Fune	ral C	hapel, p. 1 Land21214
physician and many street burial-transit and particular and partic	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as do	a consequa	uence of):	ince/	igi occii ac				2	Interval Between Onset and Death MONTHS
etached for use as Physician/Mee	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ♀ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥ ♥	23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 🗆 Feta	Ideath 3] Ectopic pregnand] Other <i>(specify)</i> _	Э			23d.	Date of deliv Month	ery Day Year
	Part II. Other significant condition	es Amak	por 1	ulting in the u	nderlying cause giv	ven in Part	Suker		obacco use c		he cause of death? bably 4 Unknown
n p	Osease, Oslix	idenia, H7	W,	TIA	, pepres	sion		24a. Was autop perfo 1 □ Yes	an 24 psy prmed? 22 No	b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
certificate rector, pag	25. Was case referred to medical examiner?	Hospital:		FD/0 / "	Oth	er 🔪		(Check only c			
Lirector: After this of a by the funeral direction: To	1 Yes 2 No 27. Manner of Death Natural 5 Pendin 2 Accident investig	28a. Date of Inju	ry	28b. Time of Injury	28c. Inju	-4-CN	28		dence 6 how injury oc		fy)
al Director: After tiled in by the funera Certification:	3 ☐ Suicide 6 ☐ Could determ		ury - At ho c. <i>(Specif</i>	ome, farm, str	eet, factory, office		28	Bf. Location (City or To	Street and Nu wn, State)	mber or Run	al Route Number,
he Funer pletely fil edical	(Check only 2 Medical one)	ng Physician: To the best of Examiner: On the basis of and manner sta	f examina		vestigation, in my	opinion, de			date and pla	ce, and due t	o the cause(s)
To t	29b. Signature and title of certifie	=M,0.			29c. Licens	1117	88		29d. Date sig	1/2-1	Day, Year)
,	30. Name and address of person Matthew King M 31. Date filed (Month, Day Year)	w completed cause of d	pee/	Road	Chester	own	, Ma	yland	1 216	20	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5perFH, G900, 2/24/2010, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Year **Physician** 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Square Hospital Center Rosedale If Under 1 Year | If Under 24 Hrs. Baltimore 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Min. 3 Yrs. Months Hours Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination to the traumatic event, If a Medical Examination or other events are events. Baltimore 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ISA Drive lace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lowers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nonso ၉ Bultimore, Md. 1urv.11 Huntinggon Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Se rvice Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Metastatic Breast Immediate Cause (Final Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) P.O. I the a 1 ☐ Yes 2 1 No detached 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performe this certificate 1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Mile of 062573 M.D 9000 Franklin Square Dr. Baltimore MD21237 30. Name and address of Debra Huttens

21. Deta filed (Month Day Year) mpleted cause of death (Item 23a) (Type, Print) MD 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decede 2. Date of Death Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2XXF 7-7-1941 NORTH CAROLINA Director 68 240-72-0611 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 6513 LIBERTY RD 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: BLACK à 3 →Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER BALTIMORE CITY SCHOOLS 12 should be filed wi h and Mental Hygier 7 is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THEODORE HAUSER ပ DOROTHY MACKEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a PRESTON MACKIN(SON) 6513 LIBERTY RD. BALTIMORE, MARYLAND 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If iter any injury or otl Pages ' 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) ARBUTUS MEMORIAL PARK 2-27-2010 | BALTIMORE, MARYLAND GONATHAN, D. HIBNIK^{2. Name and Address of Facility} PHILLIPS FUNERAL HOME, P.A. 21. Signature J Funeral Se 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. k, or heart failure. List only one causes in each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Imme te Cause (Final disea or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Due to for as a consequence of If any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 I Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autons perforr 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence Other (Specify 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Natural
Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760. Division of Vital Records, Hospital or Attending Physician: To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the

3altimore, Maryland 21215-0036

State Registrar

(Check only

29b. Signature and title of

31. Date filed (Month. Day.

and manner stated

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year SONIA FEB MARCUS 11-55 A M 20 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death LEVINDALE BALTIMORE AM N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/16/1921 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 T F MD 217-18-2984 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 USA 6431 ELRAY DRIVE, APT. A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MOLLIE ISAAC LIVINGSTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3433 RED ROCK DRIVE, LAND O LAKES, FL ERIC OSHER/SON 20a. Method of Disposition 20b. Place of Disposition (Name of ARtentification) Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) AMUNO CEMETERY 2/22/2010 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) alan Congestine Due to (or as a consequence of): 6 monto antery GOWNANY Due to (or as a consequence of):)eneutia Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

physician a s the burial-1

certificate ha

after death Director: / d in by the f

within 24 hours af

To the Funeral D

completely filled i

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical

Completed

Be

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Medical Certification:

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Funeral

Director

"natural", or items 23a or 28a-f shovedical Examiner must be notifled at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner musting.

Baltimore, Maryland 21215-0036

Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24a. Was an autopsy performed 1□ Yes 2☑No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

(Check only one)

5 Pending investigation 6 Could not be determined

varin

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

MP

68394

29c. License number

29d. Date signed (Month, Day, Year)

MB 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALNA ASNANI
NEVINDALE 2464 W. GELUCOCRE AVENUE BALTII

BACTIMORE

State Registrar

31. Date filed (Month, Day, Year)

32'. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year 2:25+M **Physician** Month 2010 MICHAEL RAY MOORE Feb /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Be Honor Hospita N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X**XM 2□ F Months Days Director 56 12 1953 NEW YORK 213-64-6998 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any highry or other traumatic event, the Medical Evernment must be maithed a once. XXYes 2 □ No BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 4000 LIBERTY HEIGHTS AVE 21207 APT B2 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 12⊒Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2XXXNo Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE 12th grade FORK_LIFT INSTRUCTOR 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RAY MOORE ၉ MARGARET T. McDONALD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Snow-Moore/Wife 1017 CEDARCROFT RD., BALTIMORE, MARYLAND 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) GARRISON FOREST 03-04-10 OWINGS MILLS, MARYLAND 21. Signature of 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Malle 1206 W NORTH AVENUE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUDCALDIR Jay /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Dulmanor. Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate 2 No 2 🗆 No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ PR/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 □Yes 2 □ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b, Signature and title of certifi 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

of pe

DHMH 17 Rev 1/2001

Michae) Moore

son who completed cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ADRIENNE NITKOWSKI 0915 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, 1 □ M 2 🛛 F Hours Min. MARYLAND 30 8236 216 Director 75 1934 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 🗆 Yes 🚈 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1510 CHESACO AVE 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) GROCERY STORE OWNER FOOD 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NICHOLAS **JAGODZINSKI** VIOLA KUCINSKI I-KOWSK! 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHESACO AVE BALTIMORE, MD 21237 KATHALEEN A. NITKOWSKI injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) ST. STANISLAUS CEM 2/24/10 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funeral ervice Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician LUIOMADOCAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last use as the burial-trans attending physician and Mellitus with Retinopathy and neuropath Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia, Gastric VICERS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Funeral Director: After this certificate I completed filled in by the funeral director, pag To Be (25. Was case referred to medical examilier?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man, er of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5038 201C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square DR. Baltimore, MD 21237 phine 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 15^{Day} Edna Overbeck PM Medical 2010 8 • 50 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Essex Riverview Care Center Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
11-22-1910 . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours 1 ☐ M 2 🛣 F Months Days Director Country)
MD 219-10-1417 98 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Dundalk 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8239 Dundalk, 21222 Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes 21 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Stoney Anna Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Turner- Daughter 4309 Ridge Rd., Chincoteague, VA 23336 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-17-10 Bayview Crematory Baltimore, MD 21. Signature of F 22. Name and Address of Facility Bradley-Ashton Funeral Home Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De it Dernen Immediate Cause (Final on (201 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work' Accident
Suicide 1 🗌 Yes 2 🗌 No after death Director: / Investigation Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009 29b. Signature and title

31. Date filed (Month, Day, Year)

EB 24 2010

MiD

US ASE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALKA WAREM FOG. EASTBRN

32. Registrar's Synature

709.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryl				d Mental Hy	giene	
			Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)	Cer	tificate of	Death		Reg. No. 2	0 - 0 5 3 8
,marke	Physicia Medi	cal	EMMA	OGUNNAIKI	E			2. Date of De Month FEBRUA	RY 11 2010	
	Examir	ner	4a. Facility Name (If not institution, give LARGO MANOR (4b. City, Town, LARGO	or Location of D	eath	4c. County of Dea	
	Funeral Director		343-86-1948	ex □ M 2X□ F 7. Age (In y	vrs. last birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, Da	y, Year) Co	rthplace (State or Foreign ountry) SERTA
	ith the Maryland 23a or 28a-f show st be notified at	ral Director	Usual Residence of Decedent	GEORGE'S	. City, Town or Loo	10f. Zip Code			10g. Citizen of What C	10d. Inside City Limits 1 ☒ Yes 2 ☐ No ountry?
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Balti	permit. Page 1 Department of Important: If i any injury or once.	(21. Signature of Funeral Service Licens		22	CTION CE . Name and Addr 474 LAND	ess of Facility		CLINTON,MA NKINS FUNER ER,MARYLANI	RAL HOME
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N O	Medical Examiner physician and the burial-transit	edical Examiner	resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. CONGEST Due to (or as a constant of the condess of the constant of the cons	IVE HEAR sequence on. NSION	T FAILUF	LE .			
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	the Hospital or hin 24 hours afte the Funeral Dirumpleted filled in Impleted filled	Medical	(Check 2 Medical Exami	ician: To the best of my kr ner: On the basis of examin e Practioner: To the best of	ation and/or invest	igation, in my opin	ion, death occurr	ed at the time, date a	nd place, and due to the	cause(s) and manner stated.
	North		29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mont FEBRUARY 1	
			30. Name and address of person who can bahram PISHDAD				E # 310	WASHINGTO	ON, DC 20032	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Kevin O'Rourke Feb 15, 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7767 Chattfield Lane 5. Social Security Number Age (In yrs. last birthday) f Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2□ F Months Days Hours Min. PA 51 174-52-8441 Jan 17, 1959 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 🗖 No MD Howard **Ellicott City** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7767 Chattfield Lane 21043 12. Was Decedent Ever in U.S. Armed Forceş? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 7 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes ZINO Specify: 3 Widowed 4 Divorced Whi 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retail 17. Father's Name (First. Middle. Last) 18. Mother's Name (First, Middle, Maiden Surname) John R. "Jack" O'Rourke Helen Casey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou O'Rourke Spouse 7767 Chatfield Lane Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 18, 2010 Glen Burnie, MD Atlantic Crematory, LLC 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythmia disease or condition resulting in death) Due to (or as a consequence of): ltypertensive Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Obesit IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform

Physician /Medical Examiner

Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0036

requires that the death certificate be executed and burialphysician attending p þ signed I Physician; The law page certificate director, this funeral After Hospital or Attending

Box 68760

P.O.

Division of Vital Records,

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Examine Physician/Medical þ Be Completed Certification: To

2 No 1 ☐ Yes 2 ☐ No 1 □ Yes Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 □ Yes 2 🗓 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Matural 1 ☐ Yes 2 ☐ No Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

H44183

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2010

Columbia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fh g901 3-1-10 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 1205 AM February 70) 7010 Ida Opher /Medical Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Baltimore Randallstown tospice Deasons 8. Date of Birth (Month, Day, Ye 10-25- Birthplace (State or Foreign Country) If Under 1 Year If Under 24 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Min Hours 1 ☐ M 2 🔀 F MD 217-12-0366 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he published once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 1 es 2 No timore MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 No Specify: Blac Baltimore, Maryland 21215-0036 Specify: Completed by 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) osmeto bais 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Las Be ovence ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 A/ Nanastery Ave., Baltimore, MD 21229 a Informant's Name/Relationship (Type. Progrand Son) Williams erik Charles 20b. Place of Disposition (Name of 20a. Method of Disposition Mayland Nationa Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 27-10 aure 21. Signature of Funeral Service Licenses eral Services 1 Pilce Yaugho C. Heete 5151 Babb. Nat'l Fice (23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** honic Obstruc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical (F FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗌 No 3 🛣 Probably 4 □Unknown 1 ☐ Yes herner's 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 🗖 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred the funeral 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign ature and title of certifier DOUS3337 February 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Mdzizua Suite 203 Secon 31. Date filed (Month), Day, Year) MA 32. Registrar's Signature State FEB 24 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Min. 1 □ M 2 💢 F Hours Director 220-36-7509 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 4343 Z1102 or items filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates the Merical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Danking event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If item 27 is marked any injury or any injury or any injury or any Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest D tarker pouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory Burial 2 Cremation 3 Removal from State Owings M 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Hore 21. Signature of Funeral Service Licensee Sykesville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as electroquence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Month Year Day 5 Other (specify) Pregnant at time of death the 9 Unknown P.O. by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: DOVE HOUS ပ 1 Yes 2 🖪 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Man of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one 29b. Signature

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30. Name and

DHMH 17 Rev 7/2009

License number

555 South Onte Street

29d. Date signed (Month, Day, Year)

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	Examir		4a. Facility Name (if not institution, give Gilchrist Center				4b. City, To					4		y of Death 1timC	
	Funeral Director		5. Social Security Number 6. Sec. 124–18–6134 1 Usual Residence of Decedent	x □ M 2 🕅 F	e (In yrs. Ias 109	t birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours		8. Date of Bir June 18	rth av, Year)	900	9. Birth	place (State or Foreign htry) Y
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S. No	If	Vas Deceder Yes, specify	/ Cuban	, Mexicar	, Puerto I	cify Yes or No- Rican, etc.)	-	Bla	ce - Americ ick, White, v: whi	etc.
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Baltimore, Maryland 21215-0036	t. Page 1 an tment of He rtant: If iten ijury or oth		20a. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cer		natory or other 11ey M	er place Iem C	ardF	eb. 2		Tin	noni		aryland
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09	te be executed nysician and he burial-transit	dical Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a Due to (or as a d.											
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 🗌	Ectopic pre							ate of deliv	ery Day Year
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			30. Name and address of person who co			3a) (Type, Pr						ti	18 W	,^cZt	NO 2120
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State of Maryland / Department of Health and Mental Hygiene

			For State	State of Man	-			d Mental Hy	giene	
			Registrar 1. Decedent's Name (First, Middle, Las	of)	Cer	tificate of L	Death	1.00	Reg. No. 2	0,05323
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and the	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	r Location of De		4c. County of D	
-100	<u></u>		SAINT VOSEPH	MEDICAL			TOWSO			TIMORE
	Funeral Director		213-30-4020	ex 7. Age (In: 74	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Irs. 8. Date of Bir lin. Jan. 6	th ^{y, Y} 1936 Ma	Birthplace (State or Foreign Courty) Tyland
	and show at		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	cation				10d. Inside City Limits
	Maryla 28a-f s atified	Director	MD Baltim	ore	Towson					1 ☐ Yes 2 🛂 No
	h the		10e. Street and Number			10f. Zip Code			10g. Citizen of What	: Country?
	ath wi	Funeral	531 Stevenson Lar	ne 12. Was Decedent Ever	in II 9 I 12 W		L286	(Specify Yes or No-	USA	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, remained other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	lf lf	Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	Black, W	merican Indian, /hite, etc. White
15-0	72 hou "nate edica	Completed	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>	(Give k	ent's Usual Occup		working	16b. Kind of Busine	ess Industry
712	within giene.	Con	Elementary/Seconday (0-12)	Coilege (1-4 or 5+)		NOT use retired)			ARC of Ba	ltimore
bu	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Surname)	
ylaı	should be file and Mental 7 is marked or raumatic eve	မ	Charles Robert Pa				Mary V	irginia C	layton	
Mar	and 2 shou Health and tem 27 is m	ì	19a. Informant's Name/Relationship (7) Joseph A. Pahr	ype, Print) N ephew		=		Rural Route Number	r, City or Town, State,	Zip Code)
Baltimore, Maryland	Page 1 an nent of He int: If item ry or othw		20a. Method of Disposition 1	Removal from State	20b. Place of Dispos cemetery, crem foreland N	natory or other place		Date /26/2010	20c. Location - City	
Balti	permit. Page 1 a Department of H Important: If ite any injury or ot once.	j	21. Sign sture of Funeral Service Liver	7	Fur	Name and Addres	ss of Facility St	terling A atonsvill	shton Schwe, Inc. tonsville,	vab Witzke
			23a. Part 1. Enter the disease or com shock, or heart failure. List only of	ne cause on each line.	e death. Do not ente	r the mode of dyin	g, such as card	liac or respiratory ar		Approximate Interval Between
, ~	Ph sician/	0	Immediate Cause (Final disease or condition	a ACUTE	RENA	L FAI	LURE	5		Onset and Death 2 DAYS
	Medical Examiner		resulting in death)	Due to (or as a co	insequence of):					
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	insequence of):					
3	icate be executed physician and sthe burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	c						
50	ate be executed physician and the burial-transi	alE	resulting in death) Last	Due to (or as a co	nsequence of):					
200	cate b physi			d			<u>-</u>			
.89	certifi inding use as	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy	le.			23d. Date of	delivery
Box	he death y the atte iched for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at tin		Other (specify)	;y		Month	Day Year
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending, completed filled in by the funeral director, page 2 should be detached for use as	ρ	Part II. Other significant conditions of SEPTIC S PNEU MON	ontributing to death but n	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	1	e to the cause of death? Probably 4 Unknown
örö	iw requ	Completed	PNEUMON	MA				24a. Was		autopsy findings available to completion of cause of
Rec	The la	Com	<u> </u>						rmed2 death	
ital	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Pla	ace of Death (C	Check only one)		
of V	Phys r this eral dir	9: To	1 ☐ Yes 2 No 27. Manger of Death	1 Anpatient 28a. Date of injury	2 ER/Outpatient 28b. Time of	t 3 DOA 28c. Injury	4 L Nursin		dence 6 Other (Sp low injury occurred	pecify)
uc	nding ath. r: Afte ie fun	icat	1 Natural 5 ☐ Pending 2 AccidentInvestigation		ear) injury	work	? Yes 2 □ No		ow injury coodinad	
Division	al or Atte s after de al Directo ed in by th	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - building, etc. (S		et, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
_	Hospi: 24 hour Funera ted fills	Medical	(Check 2' Medical Exam	sician: To the best of my iner: On the basis of exam	ination and/or investi	gation, in my opinio	on, death occurre	ed at the time, date a	nd place, and due to t	he cause(s) and manner stated.
	ithin 2 the 1		only one) 3 Certifying Nurs	se Practioner: To the bes	t of my knowledge, d	eath occurred at the	e time, date and	place, and due to the	e cause(s) and manner	as stated.
	# 3 # 8			2000000	MA				29d. Date signed (Mo	
	Á		30. Name and address of person who	completed cause of death	(Item 23a) (Type, Pr	rint)				2/204
	7		30. Name and address of person who of NEETA DESHI	PANDE M	D. 74	101 05L	ER DR	IVE 7	OWSON, N	PARYLAND
	Stat Registra	е	31. Date filed (Month, Day, Year) FEB 24 201	3. Registrar's	Signature	Kel				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death t's Name (First, Middle, Last) 2. Date of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 08/21/1915 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Days 105-12-4899 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT WILSON LANE, #522 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ 12 NURSING HOME ADMINISTRATOR NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY NEWMAN ANNE ABRAHAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARVEY PERLE / SON 104 KENDRICK PLACE, #36, GAITHERSBURG, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) BETH JACOB CONG. 2/21/2010 FINKSBURG, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on and line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): of delivery Year bute to the cause of death? Probably Unknown ere autopsy findings available ior to completion of cause of eath? 2 🗆 No ∃Yes

or Rural Route Number.

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be execu

1. Deced

10a. State

MD

Physician /Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

ò

'natural"

of Health and Mental Hygid item 27 is marked other rother traumatic event,

injury or other

Department of Important: If it any injury or conce.

The Medical

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician Physician/Medical signed I þ Be Completed page 2: Certification: To n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter I lod dyin. Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as a consequence of): c Due to (or as a consequence of): d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date Mon
Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part	. 23e. Did tobacco use contril
		24a. Was an 24b. W pr autopsy performed? 1 Yes 2 No 1
25. Was case referred to medical examiner?	26. Place	e of Death (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ No	ursing Home 5 Residence
27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could n		No

State

completely within 2 To the

Registrar

Medical

29a. Certifier

29b. Signature and

completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 31189

TOWSON MARYLAND 21204

Physician/ Medical Examiner death certificate be executed Box 68760 P.O. Records, or Attending Physician: of Vital Division

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

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Certificate:

Medical

Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death val Hygiene.

Ith and Mental Hygie 27 is marked other r traumatic event, tl

permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve

Maryland 21215-0036

Baltimore,

the burial-transi attending physician for use as the burial filled in by the funeral To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After completed

> State Registrar

31. Date filed (Month, Day, Year) FEB 2 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of co

MICHAEL J. MININSOHN, M.D. 7601 OSLER DRIVE 32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 per Phy G900 2/24/2010 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. **2010** Year 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician RIDDICK DENISE EBRA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICR 34 MAGNOUA TERRACE A-43 FREDGRICK 9. Birthplace (State or Foreign Country)
3. COLORA DO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1□M 21 F Months Days Hours 218-90-6566 46 1963 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hyglene. The strains 23a or 28a-f show then Tris marked other than "ratural", or items 23a or 28a-f show the traumatic event, it should be a single traumatic event. 1. Yes 2 No MD Director FREDERICR FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 5734 MAGNOUA TERRACE A-43 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Specify: BLACK δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISTABLES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES RIDDICK ALICE CROSS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RIDDION WOT FROMBRICA MD DOWARD BROI GRESHAM CT 7081 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 18,2010 ROBGRER MB SMITHSBURG CROM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility GARY L. ROUINS FUN, HUM C Coller Kund. 21701 110 WEST FREDERICE MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final monic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner perten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pt for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed?

Yes 2 No this certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date fired (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2010 665 PM 21 iolsinson February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Andallstown Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** 1 □ M 2 😿 F Months Days Hours NC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo MD Baltimore GWUNN Dak Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ö Brubar Cowt 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, It. M. dict Exa. in c. must 200ce. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College,(1-4or 5+) Lare Elementary/Secondary (0-12) Hair DRESSEY 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be owell Karmond Reid Marie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimone MD 21207 Margie M. 6400 Laurel Drive Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 27 2010 Windsor Mill, MD 22. Name and Address of Facility Vaushin C. Greene Furreral Services 21. Signature of Funeral Service Licensee Rolld Rundallstown, MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleratic Cardiovascelar /Medical Due to (or as a consequence of): Due to (ur as la Monsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Physician Examiner or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: 6 completely filled in by the fi ٥

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RA Randallsta 5401 Old Cowet 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/200

WW

29c. License number

29d. Date signed (Month, Day, Year)

21133

tebruary 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, 20c State of Maryland 3/2/10 TT Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Month Robinson 10:31 02 2010 Medical 4a. Facility Name (if not institution, give street and number)
Whive it is of Maryland Medical Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore, MD N/ASex 1XX M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 77 MARYLAND Director NOV. 932 219-28-2049 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2XXNo DELAWARE CAMDEN 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 64 FELLOWSHIP DRIVE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1

X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: Specify: BLACK Completed 3XXWidowed 4 □ Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BIOLOGICAL LAB TECH APG <u>8th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HENRY SCOTT ROBINSON LILLIE BRADFORD ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Robinson/Son 64 Fellowship Dr., Camden, ., 19934 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Harford memorial Aberdeen, Maryland 4 Donation 5 Other (Specify) 02 - 27 - 10FAIRVIEW A.M.E. JARRETTSVILLE, MD Signature of Funeral Service Licensee 22 Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. S PHILA.BLVD. ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final rebellar Onset and Death Physician. disease or conditi-resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) signed by the attending physician and defected for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1/2 Natural injury 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29c. License number 29b. Signature and title of မ 29d. Date signed (Month, Day, Year) NPI-1063651105 thysician 20/2010 Paul, MO; university of maryland medical center, 225 creen Steet, Baltimore, MO 21201

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) FEB 2 4 2010

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Karen Anne Schulze 2:00 pm 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Social Security Number U 0S Year olar 24 Hrs eda timore Franklin ta 9. Birthplace (State or Foreign Country) Maryland . Date of Birth (Month, Day, Year) 02/10/1955 **Funeral** Min. Days 1 □ M 2 🖺 F Months Hours 55 215 64 8310 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it with the motified at **Funeral Director** 1 ☐ Yes 2X No Middle River Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10014 Icabod Lane 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2**X** No Specify Specify: Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) L.P.N. 12th Hospital Department of Health and Mental Hygis Important: If Item 27 is marked other is any Injury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Warren Jackson Sr. Catherine Gubert ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laura Anne Bocek / Daughter 535 Freeman Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/24/2010 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List in one cause on each line. Immediate Cause (Final **Physician** Uncontrolled disease or condition resulting in death) Due to (or as a consequence of): Examiner tabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Exami sician and burial-trans Diabetes Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be 2 No 3 Probably 4 Unknown 1 TYes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 No 1 Tyes 2 🗆 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, death.

the Hospital or Attending within 24 hours at To the Funeral D completely filled it

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

9000 Franklip Square Drive, Baltimore MD, 21237 MD Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05330 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month Day **Physician** 5:48 PM tourip ebrury ZOID /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Har 8. Date of Birth (Month, Day, Year) 11/13/1923 9. Birthplace (State or Foreign Country) Virginia Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Davs Hours 1 □ M 2 🛛 F 234 32 5851 86 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show 1KIYes 2□No ral", or items 23a or 28a-f sh Examiner must be notified Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 4916 Pennington Avenue 21226 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ Specify: 3 X Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ins. Mang once. Roper-Venetian Blinds 3rd Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy Jackson Kincer Gladys Monahan ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gladys Price / Daughter 4916 Pennington Avenue Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 02/23/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemeterv 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Lice 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** oronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 **1**0 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 XYes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 KER/Outpatient 3 □ DOA Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0067421 2010

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

110

3001

South

32. Registrar's Signature

DHMH 17 Rev 1/2001

Hanover Street, Baltimore.

(Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician February 18, 2010 9:37 Bernard Warren Spahn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 18715 Sparkling Water Drive, #104 Montgomery Germantown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□ F 79 August 14, Washington, D.C. 578-34-2334 Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City, Town or Location r than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at 10a. State 10b. County 1 Yes 2 No Directo Germantown Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 United States 18715 Sparkling Water Drive, #104 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 21X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Korea Specify: Specify: White δ 3 Widowed 4 Divorced eted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compl College (1-4or 5+) Elementary/Secondary (0-12) 12 Cartographer Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important; if Item 27 is marked oth any injury or other traumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) Mary Schriver ၉ Bernard G. Spahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18715 Sparkling Water Drive, #104, Germantown, MD 20874 Jacquelin A. Spahn/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 24. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signatuse of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 M01548 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Eist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Osteomyelitis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease, End Stage Renal Disease, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Peripheral Arterial Disease has je 2 certificate 1 Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours el 29a. Certifier i 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 60417 2-22-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65C Thomas Johnson Drive, Frederick, Maryland 21702 Hemen Shah, M.D. 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of		d / Depa		Health and N	Mental Hyg		2010	05	332	
	D	,	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	th		3. Time o	f Death	
	Physicia Medi		Carlos A. Schaf						Februar	$y \stackrel{\text{Day}}{1}$	4, 2010	6:20	Рм	
	Examir	ner	4a. Facility Name (if not institution, g		er)			r Location of Death	1	4c.	County of Death			
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	and show	io	10a. State 10b. County		10c. City,	Town or Lo	cation					0d. Inside C	ity Limits	
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10	r dea		11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Decede Armed Force ed 1 \(\sum \) Yes 2	ent Everin U.S. es? . Krissa	13. \	Vas Decedent of F f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,			
980	s afte ral", c Exam	Completed by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date			X Yes 2 ☐ No	Specify: Mex	ican	- 1	Specify:Whit	e		
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Maryland 21215-0036	nd M		19a. Informant's Name/Relationshi	and Number or Rui		: City or	Town, State, Zip	Code)						
	Karl Schaffenburg/Son 117 W. Broad Street, West													
ore	of He of He If item ir oth		20a. Method of Disposition 1 ☐ Burial 2 XX Cremation	2 Bomouel from St	20b. Pla	ace of Dispo	sition (Name of	ce)	Date	20c. Lo	ocation - City or To	own, State		
Ë	ment tant: jury o		4 Donation 5 Other (Sp		Mont Cre	tgomer matori	natory or other pla y um, Inc.	Feb.	18, 2010	Bet	hesda, M	[aryla:	nd	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Servine Lie	enster Market	M0153	0 R	Name and Address bert A. Pu 557 Wiscons	ess of Facility Imphrey Function Sin Avenue,	eral Home/ Bethesda	Bethe Mar	esda-Chevy yland 2081	Chase,	Inc.	
I	Physician/ Medical		23a. Part 1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	nly one cause on each Recus	used the death line. rrent P	neumo		ng, such as cardiac	or respiratory arm	est,		Approxima Interval Be Onset and	tween	
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P.O. Box 68760	e death certifing the attending shed for use as	cial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 Live Bir 4 Pregna	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						23d. Date of deliv Month	f delivery Day Year		
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	requires that been signed should be defended	ed b	Hypertension, A	trial Fib	rillati	on, D	iabetes l	Mellitus,	1 🗆 🕆	Yes 2	X No 3 □ Pro	bably 4 🗌	Unknown	
Ö	w req	plet	Coronary Artery	Disease,	Dement	ia, D	elirium		24a. Was a		24b. Were auto	psy findings	available	
Coronary Artery Disease, Dementia, Delirium									autop perfor	rmed?	death?	·	,ause of	
E	certificate rector, pag	l as	25. Was case referred to medical examiner?				26. P	lace of Death (Chec		- 44111	4			
Σ	hysician this certi al directo	₽	1 ☐ Yes 2 💢 No		patient 2 🗆 E			ner: 4 Nursing H	lome 5 Resid	lence 6	Other (Specify)		
n of	Jing Ph	ate	27. Manner of Death 1 X Natural 5 ☐ Pending	, ,	injury Day, Year)	28b. Time of injury	wor	k?	28d. Describe h	ow injur	y occurred			
Division of Vital Records,	Attender deatlector: by the	Certificate:	2 Accident Investiga 3 Suicide 6 Could n	ot be	f Injury - At hor	me farm str	M 1 L eet, factory, office	Yes 2 No	28f Location /S	treet an	d Number or Rura	l Route Num	her	
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_	To the Hospital or within 24 hours at To the Funeral D completed filled in	Medical	(Check 2 L Medical Ex	Physician: To the best caminer: On the basis Nurse Practioner: To	of examination	and/or inves	tigation, in my opini	ion, death occurred a	at the time, date a	nd place	, and due to the ca	use(s) and m	anner stated	
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	ha		1. myan	vormed	∧ ₄		D53	367		Feb	ruary 16	, 2010)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen Hilsenhoff Shure 9, February 2010 2:55 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sunrise of Rockville Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year. 1 □ M 2 🗓 F 99 Months Days Hours 577-01-5555 Director November 7, 1910 Iowa Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, inc. Medical Examinar mant to notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 N. Adams Street Funeral United States 20850 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ģ If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Jurgen Hilsenhoff ည Christine Jensen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deane A. Shure/ Son 103 N. Adams Street, Rockville, Maryland 20850 20b. Place of Disposition (Name of commetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State February 21 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee og Lhe Co M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septic Knee Arthritis 11 months /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ours after death.

eral Director: After this certificate has been silled in by the funeral director, page 2 should Dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Aspiration Pneumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760. Division of Vital Records. e Funeral within 2 To the I

Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Shama Mittal, M.D.

32. Registrar's Signature

mula

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14816 Physicians Lane, #152, Rockville, Maryland 20850 back

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D61382

29d. Date signed (Month, Day, Year)

February 12, 2010

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Year 1 22 2010 D415AM DONNA LEE SAMPLES ebruary 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death N/A BALTIMORE AGNES HOSPITAL 8. Date of Birth (Month, Day, Yo 8/4/1942 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Days 1 □ M 2 🛛 F MARYLAND 67 217-40-4316 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No LINTHICUM HEIGHTS ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 303 NANCY AVENUE 21090 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th GRACE EXECUTIVE SECRETARY OFFICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDWIN ELMORE RUTH HELLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LINTHICUM HEIGHTS, MD 21090 JACK R. SAMPLES/HUSBAND 303 NANCY AVENUE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 2/26/2010 | BALTIMORE, MD 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intra abdomin month Due to (or as a consequence of) Sequentially list conditions, in the late of the late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 \(\subseteq \text{ Ectopic pregnancy} \) Day Month Year in the past 12 months? 1 ☐ Yes 2. No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

24a. Was an

1 □ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

BALTIMORE

26. Place of Death (Check only one)

autopsy perform

2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

FEBRUARY 22,2010

21202

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any injury or other trau
once.

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

show

ral", or items 23a or 28a-f show

'natural', or

Director

Completed by Funeral

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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sician and burial-trans physician s the burial has certificate

Records,

Division of Vital

Examiner Physician/Medical þ Completed Be ၉ o the Hospital or Attending Plantin 24 hours after death.
o the Funeral Director; After the ompletely filled in by the funeral Certification: Medical

> State Registrar

DHMH 17 Rev 1/2001

within 24

25. Was case referred to medical examiner?

29b. Signature and title of certifier

2 No

5 Pending investigation

6 Could not be determined

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

f person who completed cause of death (Item 23a) (Type, Print)

1 Tes

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier (Check only one) 2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day February Da Year **Physician** 0706 AM 18 2010 Robert Peter Semies /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Beelhimore Baltmore n/a If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 1939 Director Jan 28, Maryland 219-26-9452 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be retified at 1 Yes 2 □ No Baltimore Maryland n/a 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? United States 21211 2095 Rockrose Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 X2 Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11, Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S.P.S. 4 <u>Finance</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Rice Peter Pius Semies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alisa Chernack / Attorney 3300 North Ridge Road, Suite 235, Ellicott City, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/23/2010 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) e of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. ignatu 4107 Wilkens Avenue, Baltimore, Maryland 21229 3 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Incumon tis Aspiration **Physician** disease or condition resulting in death) /Medical obstructed with Chronic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-trans Due to (or as a consequence of): aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> delevos us 1 ☐ res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perlorm 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 res 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA spital or Attending Physicours after death.
neral Director: After this y filled in by the funeral di ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident

requires that the death certificate be executed Box 68760, P.0. of Vital Records,

Baltimore, Maryland 21215-0036

Pages nent of I

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certificate has

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within 24 hours a

To the Funeral C

completely filled

Medical

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

4 ☐ Homicide

Registrar DHMH 17 Rev 1/2001

State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

750693

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 18, 2010

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alden G. Peuples, up Snai ttospital of Baltimore

31. Date filed (Month, Day, Year)

12. Registrar's Signature (Month)

and manner stated

avid Scott		State of Maryland / Department of Health and Mental Hygiene - For State Certificate of Death Peg No. 2010 0533
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death
Medical Exami	ner	David Scott February 17, 2010
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Country of Death 4d. Country of
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Min.
Director		218-86-65/2 1×M 2 F 35 Yrs. April 2, 1974 Country) Md.
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	ě	Md. NA Baltimore 1 1 Yres 2 No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
with the is 23a c		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
rs after ural", miner	à	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)
21215-0036 and be filed within 77 Mental Hygiene. marked other than c event, the Medical	dmo	17. Father's Name (First, Middle, Last) Residentia Counselor NCIA 18. Mother's Name (First, Middle, Maiden Surname)
21215-0C uld be filed wir Mental Hygien marked other c event, the M	Be C	David Lee Scott Sc Diane, Durant
2121 hould be find Mental is marked atic event,	2	19a. Informant's Name/Relationship (Type, Print) Mc (er) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
imore, MD 2 Pages 1 and 2 shou nent of Health and N ant: If item 27 is n or other traumatic	-	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 No Burial 2 Cremation 3 Removal from State crematory or other place) 4 Departion 5 Other Specify We stern State
Baltimo permit. Page Department Important: injury or otl		4 Donation 5 Other Specify: Western Star Butto, IVIA, 21. Signature of Funeral Service Licensia 22. Name and Address of Facility Seph L. Russ Funeral Home P.A.
	-	23a Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician	ı	failure. List only one cause on each line. Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
	ᅵ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
. 0 •	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):
rransit	EX	events resulting in death) Last Due to (or as a consequence of): d.
Box 68760, death certificate be executed the attending physician and of or use as the bunal - transit	ledical	UNPENDED AMENDED
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Sox 6876 leath certificate e attending phy for use as the l	Physician/N	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
· č × č		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
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ords, aw requir as been s	plete	24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death?
tal Rec cian: The li certificate h	Com	1 ✓ Yes 2 No 1 ✓ Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requir is after death al Director: After this certificate has been seled in by the funeral director, page 2 should the	Be	25 Was case referred to medical examiner? 1 Yes 2 No Hospital 1 Inpatient 2 Residence 6 Other.
J of J Jing Phy After tl funeral	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot
	catio	1 Natural 5 Pending Investigation 2 Accident Investigation 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division Hospital or Attene 24 hours after death Funeral Directors	ertification:	Suicide 4 W Homicide Solicide Solicide Solicide Could not be determined (Specify) Local Street Solicide Could not be determined Solicide
	ပ	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		O.C.M.E. February 18, 2010
3		30. Name and address of person who completed cause of death (Item 23a)
€/		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regist	tate trar	31. Date filed (Month, Day, Year) SEB 2 4 2010 32. Registrar's Signature
DHMH 17 Rev 1/2	001	OUNTE ORIGINAL
OCME 2006		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 19 DOROTHY STEIN 2010 4:53 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 10991594917 MD Director 217-05-1967 92 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6711 PARK HEIGHTS AVENUE, #214 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🔏 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: WHITE 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PROOFREADER TYPESETTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **JACOBSON** ELIZABETH RABINOWITZ permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2703 MOORES VALLEY DRIVE, BALTIMORE, MD INA COHEN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP CEM: 2/21/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS.. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and or use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Yes 1 ∐ Yes 2 № 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Tyes 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 2 Accider
3 Suicide after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of pry knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of pry within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/20/10 Ounow.

State Registrar ONSO11 MD 21204

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 17 2010 08:30A™ RENA SUGAR Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4730 ATRIUM COURT, #327 BALTIMORE OWINGS MILLS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD 1 □ M 2 🛣 F Days Months Hours Min. 0171171913 214-40-4065 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Owings Mills or 28a-f 1 Yes 2 No PIKESVILLE MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Examiner must be Funeral items 23a 4730 ATRIUM COURT, 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed WHITE the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mential Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ **JACOB** SHARP CLARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REGINA TABACKMAN / NIECE 3709 THOROUGHBRED LANE, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State BALTIMORE HEBREW 02/21/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Hospital 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No 1 Tes ☐ Accident☐ Suicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier **Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

State Registrar I Crossvoade Misuite 400

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 05339 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY DAY 9 2010 02:25 HOWARD SCHULMAN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death **TOWSON** BALTIMORE GILCHRIST HOSPICE CARE If Under 1 Year Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs._ **Funeral** Days Months Hours Min. NY Director 062-16-1274 88 Usual Residence of Decedent shov 10a. State 10h County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No FL PALM BEACH BOYNTON BEACH 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 104 SAUSALITO PLACE 33436 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 X Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DIAMOND SALESMAN **JEWELRY** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **EDNA** RUBLOFF CARL SCHULMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6489 NW 65TH WAY, PARKLAND, FL 33067 NORMAN SCHULMAN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) BETH MOSES CEMETERY 2/22/2010 PINELAWN, NY Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final erebrovasc Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, i.e. fing to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b page 2 s autopsy certificate 2 No 1 \sum Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No lospice ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No

Division of Vital Records, P.O. Box 68760

february 19,2010

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within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral

Accident

29b. Signature and title of certifier

29a. Certifier

Investigation 6 Could not be Suicide
Homicide determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

(20110

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 18 2010 08:50A M HAROLD SILBERG Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME PIKESVILLE BALTIMORE 9. Birthplace (State or Foreign Country) MD Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. **Director** 216-16-2180 85 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 💢 No MD BALTIMORE RANDALLSTOWN 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8409 ALLENSWOOD ROAD USA 21133 items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕻 No Specify. Specify: "natural", 3 Widowed 4 Divorced WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Heath and Mental Hygiene important: If item 27 is marked other thin any injury or other traumation. SALESMAN FURNITURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ MCDONALD WILLIAM GOLDIE SILBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA SILBERG / WIFE 8409 ALLENSWOOD ROAD, RANDALLSTOWN, MD 21133 Baltimore, 20b. Place of Disposition (Name of ANSHE MURIAH CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 2/21/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Si of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause liven in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy perform 1 Tyes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month.

Registrar

State

30. Name and a

31. Date filed (Month, Day,

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ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARY GERTRUDE UNSOELD TURBEVILLE February 2010 2:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE CENTER Baltimore County Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month Day, 1 🗆 M 2 🔀 Months Min. Mary Land 216-24-9350 81 Director Usual Residence of Decedent Show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3838 Roland Avenue, #508 21211 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 ♥ Widowed 4 □ Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Clerk ur beville, Mary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bartholomew Unsoeld Regina Shepp 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Heller 2909 Conroy Court, Apt D, Parkville, MD 21234 (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gardens of Faith Cem 2/26/2010 Rosedale, Maryland 21. Signature of Fune at Service Liberto Martin D. Law MITCHELL-WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or o, implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Day Month Year ned by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò s been signe should be a Records, 1 Yes 3 Probably 4 Unknown Completed No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has b director, page 2 s autopsy death? perform No Yes 1 🗌 Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA tosinice this Other (Specify) 28a. Date of injury 27. Manner of Deatl 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No the Funeral Director: After death.

The Funeral Director: After the function of the function o Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death baccurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F 29b. Signature and title of certifie George Homawi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles street, Towson, MO 21204 6701 N. HIPKNEUMI, MO 31. Date filed (Menth, Day, Year) 32. Registrar's Signature State FEB 24 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 ear FEBRUARY 8:55 P MARJORIE TYNER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL HOSPICE OF THE CHESAPEAKE LINTHICUM HEIGHTS If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🏻 F Days MARCH 9 Hours Min Months Yrs 1925 WASHINGTON, DC Director 150-18-7991 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 No LANHAM MD PRINCE GEORGE 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral U.S.A. 20706 7210 LOIS LANE 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Was Deceden ____ Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. or, 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY GOVERNMENT 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FLORA SIMMONS FRED TYLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7210 LOIS LANE LANHAM, MD 20706 1 and 2 s of Health item 27 i DEBORAH HAWKINS/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Removal from State 1 Donation 5 injury or 2-16-2010 LAUREL, MD MARYLAND NATIONAL 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses any in 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC BLADDER CANCER Physician/ 2 years disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 4 No Month Day Year Pregnant at time of death the a 1 L Yes 2 L 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) House examiner? Other: 4 Nursing Home 5 Residence Other Specify 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending within 24 hours area co...
To the Funeral Director: Aft 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

STEPHANIE TRIFOGLIO,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signatur

1 XI Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D37934

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MD 7500 GREENWAY CENTER DRIVE SUITE 430 GREENBELT, MD 20770

29d. Date signed (Month, Day, Year)

2-12-2010

			For State Registrar	State of Ma	rylanc		artment of H		Mental H	ygiene Reg. No.	2010	05343
	Physicia	n/	Decedent's Name (First, Middle, ETTLECTA, TIAN)	,	-				2. Date of D Month FEBRU		7, 2010	3. Time of Death
	Medic Examin		FELICIA TAN 4a. Facility Name (if not institution, NATTONAL, TN		HEALT	TH TH	4b. City, Town, or BETHE			4c.	7, 2010 County of Death MONTGOME	6:45 A ^M RY
	Funeral Director		5. Social Security Number		(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			9. Birth Coun Ban	olace (State or Foreign try) amas
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	Maryla 28a-f s otified	Funeral Director	none		Na	ssau						1 🏻 Yes 2 🗆 No
	h the	al Di	10e. Street and Number				10f, Zip Code			10g. Citi:	zen of What Cour	ntry?
	ath wil	uner	Gambier Village Douglas Road none Bahamas 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - Ar									
Baltimore, Maryland 21215-0036	e fled within 72 hours after death with the Maryland the Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	1 Never Married 2 Married 1 Yes 2 X No									Black, White,	
2-0	2 hour	plet	Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Busine									
12	ithin 7 ene. r than the Mo	Com	Elementary/Seconday (0-12) 6th	College (1-4 or 5+)	life. DO	NOT use retired)		, and the second			
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ē,	and Hea tem		Zennetta Thurst 20a. Method of Disposition	•	20b. Pla	ce of Dispos	er Villag		.as Koad		sau, Bah cation - City or To	
Ē	0		1 Burial 2 □ Cremation Donation 5 □ Other (S)			-	atory or other place		6/2010	Nass	sau, Bah	amas
Salt	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Li	censee / 00			Name and Addres					
4217 Ninth Street, NW Washington, DC 200												
	Immediate Cause (Final										Interval Between Onset and Death 2WEEKS	
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)	y Phys ar this eral dii	e: 10	1 Yes 2 No 27. Manner of Death	1 Unpatier 28a. Date of injury	2	8b. Time of	28c. Injury	4 ☐ Nursing at	Home 5 Res		Other (Specify occurred)
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Division of Vital Records,	to the flospital or Attending Physician: he fa within 24 hours after death. To the Funeral Director. After this certificate ha completed filled in by the funeral director, page	27. Manner of Death 28a. Date of injury 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred 28d. Descri										
	e Hosp 124 hou e Funel eleted fil	Medical	(Check 2 Medical Ex	Physician: To the best of manniner: On the basis of exa Nurse Practioner: To the b	mination a	and/or investi	gation, in my opinio	n, death occurre	d at the time, date	and place,	and due to the car	use(s) and manner stated.
:	vithir To th	2	29b. Signature and title of certifier				29c. License			· · ·	e signed (Month,	
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	H		30. Name and address of person w RACHEL GREE			10 CE	NTER DRIV	VE, BETI	HESDA, M	ARYLA	ND 20892	2
	Stat		31. Date filed (Month, Day, Year)	32. Registrar	's Signatu		del.					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4:50 **★** M **Physician** 01ena Terebuch 17 2010 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Burnie Health & Rehab Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 219 34 4270 84 03/05/1925 Ukraine Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director **Baltimore** Anne Arundel Maryland 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number or items 23a or 21225 UKRAINE 107 - 15th Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic. Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🔼 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) South Baltimore Elementary/Secondary (0-12) College (1-4or 5+) General Hospital Kitchen Worker 3rd 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Demetro Dubnyczka (not available) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Jaroslaw Terebuch / Husband 107 - 15th Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Michael Ukrainian 02/22/2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 mus namerouske Sa. Part 1. Enter the disease, implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Its mily one cause on each line. BARKI'NSON'S Immediate Cause (Final **Physician** 15 YEMY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation death. 2 🗆 No 1 ☐ Yes 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760. Division of Vital Records. Hospital or Attending after death within 24 hours a To the Funeral C

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D37111

29c. License number

30015. HAWOVERST MJ 2/225

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 05345 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Darlene Frances Vukov 6:45 P M 16, 2010 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Catonsville 6052 Moorehead Road 8. Date of Birth (Month, Day, Year) June 20, 1960 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🖾 F Months Days Hours Maryland 49 Director 218-52-2848 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: if item 2.13a or 28a-f show amy Injury or other traumatic event, It is Medical Evant in an two matths of any Injury or other traumatic event, It is Medical Evant in an two matths of any injury or other traumatic event. 1 ☐ Yes 2 No Catonsville Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21228 6052 Moorehead Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Customer Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty J. James Carlton L. Haynes ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6052 Moorehead Road; Catonsville, MD 21228 Joseph Vukov Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 2/22/2010 Baltimore, MD Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catons Ville, Inc. 21. Signature of Funeral Service Dicens 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Metastati omenths **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, busing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed ∄09289 xog Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Certification: To 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE STAGNES COLE 900 CATON

State Registrar 32. Registrar's Signature

10-00154 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Barbara Vanlue State of Maryland / Department of Health and Mental Hygiene 05346 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2207 hrs **Medical Examiner** January 5, 2010 Barbara Ann Vanlue

4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's 4922 LaSalle Road, Room 524 Hyattsville 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Country) NC Days Months Hours Director 577-68-1539 1 M 2 X F 12/08/1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. **Bladensburg** Prince George's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4202 58th Ave. Apt# 20712 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 2 XXMarried 2 X No Yes Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 2 or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Federal Government Office Cleaner 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Walter Boyce

19a. Informant's Name/Relationship (Type, Print) Bernice Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joeratta Bennett/Daughter</u> Bonham Circle Manassas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 Cremation 3 🦳 Removal from State Department of Important: I 4 Donation 5 Other Specify Washington Nat'l. Cem 1/14/2010 Suitland, MD 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service License 4217 9th ST NW Washington, DC 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Complications of Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Associated with Hydrocodone Toxicity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ed by the attending physician and detached for use as the burial - transi Ca X UNPENDED AMENDED Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b ۵ 1 Yes 2 No 3 Probably 4 V Unknown **Diabetes Mellitus** Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day, Yaar) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 16, 2010 30. Name and address of person who completed cause of feath (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State Registrar

ORIĞINAL

DHMH 17 Rev 1/2001 OCME 2006

			For State of M	aryland		rtment of F		Mental Hy	giene		0 = 0 7
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Death		Reg. No. 2		05341
	Physicia	n/						2. Date of Dea Month	Day	010	3. Time of Death
	Medio Examin		Louise R. Van 4a. Facility Name (if not institution, give street and number)	.n		4h City Town or	Location of Death	Februar	y ZU Z		9:30 A M
	Examili	eı	5607 McKinley Street				resda			gomer	v
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year Months Days		8. Date of Birt	h	9. Birthr	place (State or Foreign
	Director		577-50-5413	81	Yrs.	Months Days	Hours Will.	February	22, 1928	Washi	ngton
	nd how at	٦٢	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				1	10d. Inside City Limits
	faryla 3a-f s iffied	ect	Maryland Montgomery			Rot	hesda				1 Yes 2 No
	or 28	Dir	Maryland Montgomery 10e. Street and Number			10f. Zip Code	nesua		10g. Citizen of	What Cour	
	s 23a	Funeral Director	5607 McKinley Street			20	817	τ	Jnited :	State	s
	death item		11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S		Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
36	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Me Ical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 3 🕱 Widowed 4 ☐ Divorced Year or Dates	No	1	☐ Yes 2 X No	Specify:		Specify		
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7	withi		12		Executi	ve Adminis	trative As	sistant	National	Insti	tute of Health
Maryland 21215-0036	filed tal Hy ed ott	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan		Maiden Surnam	e)	
3	uld be d Men narke natic		Lauriston Ramsey				Elaine				
<u>≅</u>	1 and 2 should be file of Health and Mental H f item 27 is marked of r other traumatic ever		19a. Informant's Name/Relationship (Type, Print)		1	g Address (Street a					· ·
ē,	and Heal Item	1	Margo L. Vann / Daughter 20a. Method of Disposition	20b. Pl	lace of Dispos	sition (Name of	1	Data	20c. Location		land 20877
آ س	Page 1 nent of i ant: If it ury or o		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ce	emetery, crem	n Crematory of other place		uary 23,		,	,
Baltimore,	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service Licensee	meti					Alexandr:		Chase, Inc.
m	S a m S	0.0	John Sprance	M0136	$50 \overline{75}$	57 Wiscons	in Avenue,	Bethesda,	Maryland	1 20814	4–3501
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P.O. Box 68	v requires that the death certific tbeen signed by the attending should be detached for use as	Physician/M	III trie past 12 montris f	2 Fetal	Ideath 3 🗌	Ectopic pregnance Other (specify)	у			ate of delive onth	ery Day Year
ň.	the a	ysic	1 Yes 2 XNo 4 Pregnant a 9 Unknown	t time of de	eath 5	Other (specify)					
J.	that the	by P	Part II. Other significant conditions contributing to death b	ut not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
	uires n sigr ald be		Coronary Artery Diseas	е				1 🗆 ነ	∕es 2 X No	3 🗆 Prof	bably 4 🗆 Unknown
Ö	w req	plet	S/P Aortic Valve Repla	cemer	nt			24a. Was a		Were autor	psy findings available mpletion of cause of
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<u>a</u>	sian; ertifica ctor,		25. Was case referred to medical examiner?		anger-		ace of Death (Chec		A		
\leq	Physic this ce	မ	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpati		ER/Outpatient	1	4 ☐ Nursing H	ome 5 X Resid)
0	ding F h. After i funera	ate	27. Manner of Death 1 ▼ Natural 5 □ Pending (Month, Day (Month, Day)		28b. Time of injury	28c. Injury work M 1 🗆	≀at ? Yes 2 □ No	28d. Describe h	ow injury occurr	ed	
S10	Attender deat	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	ury - At hor	me, farm, stre		res 2 🗆 NO	28f. Location (S	treet and Numb	er or Rural	Route Number.
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s		4 Homicide determined building, etc					City or Tow			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	ospita hour unera ed fille	edical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e								
	the H hin 24 the Fi	Me	only one; 3 Certifying Nurse Bractioner: To the			eath occurred at the	time, date and pla	ce, and due to the	cause(s) and m	anner as sta	ated.
	5 Vit	X	29b. Signafure and little or certifie			29c. License			29d. Date signe		
			Velex James	0011 //	220) (75= - 5	D320)33		Februar	y 22,	2010
	25		30. Name and address of person who completed cause of d Peter G. Hamm, M.D. 5530			int) Avenue #9	30. Chev	v Chase	. Marvl	and 2	0815
ı	Stat	e	31. Date filed (Month, Day, Part D 0 4 00 22 Registry	's Signatu		fourer		, 3	, ,		
	Registra	ır	FED 24 ZUIU C	Conserva	1.	yearre					

			For State Registrar	State of M	arylan		artmei <i>tificat</i>			and N	nental Hy	/gien	2010	05	348
	Physicia Medic	cal	Decedent's Name (First, Middle, Las Jacqueline A. Va Facility Name (if not institution, give	tter-Moor	e e						2. Date of Do Februa	ary	r9, 20 r	3. Time o	
	Examin	ier	5819 Tudor Lane 5. Social Security Number 6. Se		o do um to	ast birthday)	N.	Town, or Bether 1 Year	Location of sda		O Data of Di		Montgon	ery	-
	Funeral Director			M 2 🖾 F	5		Months		Hours	Min.	8. Date of Bi (Month, D Nov. 12	195	5 Iow	thplace (State ountry) a	or Foreign
	Maryland 28a-f shov otified at	Director	10a. State 10b. County Maryland Montgome	ry		y, Town or Loc Potoma	С							10d. Inside C	ity Limits
	s 23a or	Funeral D	10e. Street and Number 15801 Glacier Cour	rt				5 Code 878					Citizen of What Co	-	
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	출	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.					spanic Origin, Mexican Specify:		cify Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify: W		
21215-0036	vithin 72 hou jiene. ir than "natu the Medical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Seconday (0-12)		5+)	16a. Deced (Give I life. Do Nurse	kind of wo O NOT us	rk done di	ition uring most	t of worki	ng	ľ	Kind of Business	Industry	
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, Mar	nd 2 shou ealth and m 27 is n		19a. Informant's Name/Relationship (Ty Peter J. Vatter/E										or Town, State, Zi _l aryland		
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		C	lace of Dispo emetery, crem opolitar	natory or o	other place) F	ebrua 2010	ry 23,		Location - City or xandria, V		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	Luit	M015	Rối 48 300	bert A West	d Addres Punt Monte	hrey"i omery	unera Aveni	1 Home/R ie, Rockv	ockv ville	ille, Inc. , Maryland	20850	
U2D.	e be e ysiciai e buri	dical Examiner	23a. Part . Enter the disease or compance, or heart failure. Ist only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or impury that initiated events resulting in death) Last	a. Gliobla Due to (or as C. Due to (or as Due to (or as Due to (or as	as toma a consequa a consequ	a Mult ence of):			s, such as	cardiac o	r respiratory a	rrest,		Approximat Interval Bet Onset and I 2 year	hwaan
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	l death 3	Ectopic Other (s _i		/				23d. Date of de Month		Year
Division of Vital Records, P.O.	quires that the consigned by the details and be detailed.	ted by PI	Part II. Other significant conditions co	ntributing to death b	out not resu	ulting in the u	nderlying	cause give	en in Part I	l.			use contribute to		
Recor	: The law re cate has be ; page 2 sh	Completed									24a. Was auto perfe 1 \(\sum \) Yes	psy ormed?	prior to death?	topsy findings a completion of c	available ause of
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 D	Otho	ce of Deat			donon	6 ☑ Other (Spec	Parents	200
ion of	tending Phy leath. :or: After thi the funeral	Certificate: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of inju (Month, Day	ry v, Year)	28b. Time of injury	M	8c. Injury work?	at	2	28d. Describe			WKÇS I GEL	ice
Divis	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the		4 Homicide determined	28e. Place of Inju building, etc	C. (Specify))			-		City or To	wn, Stat			er,
	he Hos iin 24 hc he Fund hpleted	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurs	ner: On the basis of e	xamination	and/or invest	igation, in	my opinior	 death oc 	curred at	the time date:	and place	e and due to the	ause/s) and ma	nner stated
			29b. Signature and title of certifier	Shame	el.	- D	290	c. License	number	96			ate signed (Monthernance)		
	10		30. Name and address of person who c		,		,	Blvd.			400, WI		on, Mary		 0902
	Stat Registra		31. Date filed (Month, Day, Year)	32. Regi r ra	ar's Signati	ure	has	11							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 05349 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19ay Month Feb 2010 Lucille Varella Molly 11:42 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6409 Danville Avenue N/A Baltimore City 8. Date of Birth
(Month, Day, Year)
Capt. 26, 1935 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 🔀 F Hours **Director** Yrs 218-36-2285 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No N/A MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6409 Danville Avenue 21224 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: SpecifyWhite Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Retail 12 Years Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kathleen Rabaneau George Braunschweiger 19a. Informant's Name/Relationship (Type, Print)Paughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria A. Varella-Cain 1608 Evergreen Drive Dundalk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other pla Valley Mem. Gdns. 2/24/2010 Timonium, MD Dulaney 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a art 1. Enter the disease or complications shock, or heart failure List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final duear Physician/ disease or condition resulting in death) conna Medical **Examiner** pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): by the attending physician and tached for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown 9 Unknown P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob co use contribute to the cause of death? [호 Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of oeuse of death? 24a. Was an has performed? Yes 2 No 2 4 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this f Death 28a. Date of injury (Month, Day, Year) 27. Mann 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work death. 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direc 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

005

me and address of person who completed cause of death (Item 23a) (Type, Prig

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D20, 2010 **Physician** February 5:35amM Henry Thomas Wingo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 24, 1924 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex Funeral Months Days Hours Min 1√2 M 2□ F 85 Director 578-<u>22-5626</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Eldersburg 1 □Yes 2√□No MD Carroll Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 6502 Ridenour Way East 2B by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Y Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. Specify: White 3 Widowed 4 Divorced WWII Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. em 27 is marked other than NSA NSA Employee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Burrows Henry Dorset Wingo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau once. 6502 Ridenour Way East, 2B, Eldersburg, MD 21784 Marcia E. Wingo (spouse) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date All County Cremation 2/23/2010 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 Blian 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myelo cenery Clytemia Physician monte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as this is the conditional of the cause of t Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1∐Yes 2∐Ho 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sther (Specify) Hospice 1 ☐ Yes 2 ☐ 1/0 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D00624415 2-24-10 completed cause of death (Item 23a) (Type, Print) rigness Why#106 Eldersburg 380 31. Date filed (Month, Day, 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#17perFH, G900, 2/24/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** SABRINA, TERIANNA, WALTON 00:05AM Feb 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 12 saltimore UMMC 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Min N/A 0 MD Director Feb 172010 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evainmer must be notified at 28a-f shov MD Baltimore Pikesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 6961 Brookmill Road 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black þ 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item. Elementary/Secondary (0-12) College (1-4or 5+) Never employed Never worked 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rica Richard Walton Candise Waterbury ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother Candise Waterbury / 6961 Brookmill Road, Pikesville, MD 21215 Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne, MD 02/26/2010 Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Road, Halethorpe, MD 21227 21. Signature of Funeral Service Licenses ma MO1452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAILURE RESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DILATED CARDIOMYOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed PULMONARY HYPOPLASIA and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 2 □No 1 Ves To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 patient 2 ER/Outpatient 3 DOA this (Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation hours after death.

uneral Director: A

sly filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , MD Paaaa5 02/18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD KONDURU KAUITHA, 295 GREENE ST 21201 BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 24 2010 Registrar

DHMH 17 Rev 1/2001

Cornelius Edward \	1	For State	State of Mary			nt of Hea te of Dea		Mental I		2 0 Reg. No.	10 053	5
Physician/		egistrar . Decedent's Name (First, Mic	idle,Last)						2. Date of De	ath	3. Time of Death	_
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Funeral Director	5	5. Social Security Number	6. Sex		yrs. last birth	day) If Und	der 1 Year ths Days	If Under 24H Hours M	in		Foreign	
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MOFe, Pages 1 arent of He mit: If ite		1 X Burial 2 Cremati	ion 3 Remova	I from State		ry or other place			10-110			
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Physician	1	23a. Part I. Enter the disease,		at caused the	death. Do not						rt Approximate Inte	erval
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Examiner		or condition resulting in death		s a conseque	nce of):	· · · · · · · · · · · · · · · · · · ·	_					
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Box 68760, the death certificate by the attending physical for use as the but the surface of the but the surface of the but th		F FEMALE: 3b. Was decedent pregnant in	the m	es, outcome of re birth	f pregnancy	Fetal deat	ь з Г	Ectopic preg	enancy	23d. Date of o	delivery Day Year	
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J. Box it the death or by the attent sched for us	2	1 Yes 2 No 9 L	Jnknown g Ur	known								
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death To the Funcal Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the by completely filled in by the funeral director, page 2 should be detached for use as the by concluded.		Part II. Other significant con-	ditions contributing	g to death but	t not resulting	in the underlying	ng cause gi	ven in Part I.			oute to the cause of death	
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Division of Vital Records, its or Attending Physician: The law requirest and a reder death. In Director: After this certificate has been seled in by the funeral director, page 2 should be extended to the presence of the page 2 should be a stiffered for To Be Commission.	ין ע	25. Was case referred to medi examiner?						of Death (Che	ck only one)			_
Physician this contained and the CT.	٩L	1 ✓ Yes 2 No	Hospital: 1						sing Home 5	Residence 6		
ing Physical directions of Virtual direction		27. Manner of Death 1 Natural 5 Death	ro(M	ate of Injury onth, Day,Year) ND:	FOU	ime of Injury	-	y at Work?		e how injury occurre anged self	ed .	
ivisior or Attendather death Director:	Ĭ	~ r	vestigation Feb	19, 2010	2058	hrs		es 2 V No	006 1	(Otro-st and Normbo	a as Dural Doute Number	City
Divis pital or At ours after d filled in by	rincation	de	ould not be			rm, street, facto	ку, опісе ві	inding, etc.	or Town		r or Rural Route Number,	City
ospita hours ly fille	3	4 Homicide 29a Certifier	Physician: To the	my) Multi-F			ha tima dal	to and place a				_
Division Division To the Hospital or Attent within 24 hours after death within 24 hours after death completely filled in by the	<u> </u>	(Check only	xaminer: On the ba	sis of examina	ation and/or in	ivestigation, in r	my opinion,	death occurre	d at the time, da	te and place, and du	ue to the cause(s)	
to the state of th	ĕ -	29b. Signature and title of cert	and mann	er stated.		2	9c. License	number		29d. Date signe	d (Month, Day, Year)	
		Wille 1	100/1	n/			O.C.N	Л.E.		February 20), 2010	
	\vdash	30. Name and address of pers	son who completed	cause of death	n (Item 23a)							
		Melissa Brassell, M				111 Penn S	Street, Ba	altimore, M	D 21201			
Stat	te	31. Date filed (Month, Day, Yea		Registrar's S	ignature /	bartel						

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Billy Watson 1:45 AM 18 February 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 🌠 2 🗆 F Months Days Hours Min 8-24-1936 Country) NC **Director** 241-50-3307 73 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho with the Maryland 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6514 St. Helena Avenue 21222 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Construction Supervisor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Watson Edna Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Kwiatkowski -Daughter 231 Detroit Ave., Baltimore, MD 21222 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2-23-10 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home 2134 Willow Spring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) ovonavy Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 2 Accident after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours 1 Left Section To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) AMMon D0069223 February, 18, 2010

Registrar
DHMH 17 Rev 7/2009

State

Juan A Morales-Tornes, MD 4940 Eastern Avenue Baltimore, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed (Month, Day, Year)

FEB 24 2010

WILLIAM, STELLA Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Manth 2Day Stella Agatha Williams 2010 4:45P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist HOspital Takoma Park Montgomery 5. Social Security Number 9. Birthplace (State or Foreign Country)
So. America 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 M 2 XF Days Hours Min. 07-03-1919 none 90 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring ō 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 9304 Compton Street 20901 Guyana, So. America items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify: Black 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. $\overset{\text{Elementary/Seconday (0-12)}}{12\text{th}}.$ College (1-4 or 5+) 럘 Housewife Domestic Be Department of Health and Nental Himportant, if item 27 is marked oth any injury or other traumastic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Mcrae MArgaret Culley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Jarvis/daughter 9304 Compton St. Silver Spring, Md. 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/1/2010 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. Alexandria, MAISHELL 22. Name and Address of Facility HAISHAIL S FUHERAL HOME 4217 9th. St. N.W. Washington, D.C. 20011 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final CARDIAC Onset and Death ARRYTIMIA -¢hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner como NARY Planting Helly list evan 86 me. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical ANASMI that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year the detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 2 X No Yes 2 INO 1 Tyes Division of Vital 25. Was case referred to medical or Attending Physician: director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check To the 3 Certifying Nurse Fractioner T, the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) min 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADVONTLIT MOSP, TAKOMA PARK SHAMIN WASHINGTON 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM 120b, perfff, G900, 2/24/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:00 A M Medical e (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death
RaHimore **Examiner** 11-10 Lutherville er 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If L Jr 8. Date of Birth . Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖬 F Min. (Month, Day, Yrs. **Director** Show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 28a-f 1 🗆 Yes 2 🗶 No 10f. Zip Code 10g. Citizen of What Country? ö permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be 100e. Funeral 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married 3 Widowed 4 Divorced ģ Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) University Be ather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, မှ umi 20b. Place of Dispo 1 MBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Full eral Ser 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final neart Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of Examiner vel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 | Yes 2 L 9 | Unknown 9 Unknown or Attending Physician: The law requires that the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2**X** No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurses Practioner: To the best of my Impelledge, death undust at the thire, date and plane, and date to the to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ဂ္ rescen who completed cause of death (Item 23a) (Type, Print)

CON MO 10755 Falls Rd Soute 20 30 Name and address of person 16 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FFBRUARY 18 2010 12:55am **Physician** WIELEPSKI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD BEL AIR UPPER CHESAPEAKE MEDICAL CTR 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F APRIL 18,1945 MARYLAND 217 50 2232 64 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It e Modical Exporter must be rediffed at 1 ☐ Yes 2 No DARLINGTON HARFORD Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21034 3603 DAY ROAD Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exemi 1 ∐Yes 2 DNNo If Yes, Give Year or Dates: Specify: WHITE 1 Never Married 2 Married 1 □Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FLOWERS FLOWER MERCHANT Ó 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VERONICA BARON WIELEPSKI JOSEPH ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3603 DAY ROAD DARLINGTON, MD 21034 JOSEPH WIELEPSKI/BROTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/10 GARDENS OF FAITH BALTIMORE 4 ☐ Donation 5 ☑ Other (Specify) FNIOMBMENT: 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Fun at Sen ice Licensee MD 21237 1211 CHESACO AVE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? has this certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient မ in by the funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide

ですものといっていのドンソソののはの Division of Vital Records, P.O. Box 68 signed by the a d be detached for

attending p

the Hospital or Attending hin 24 hours after death. within 24 hours after death To the Funeral Director: completely filled

29a. Certifier

Medical

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

615

31. Date filed (Month, Day, Year) State FEB 24 2010 Registrar

32 Registrar's Signature

h

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Physician/ February 2010 11:55 A M John Κ. Wentz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Min. (Month, Day Hours **Director** 306-05-4165 94 June 1915 Minnesota Usual Residence of Decedent or 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral 301 Russell Avenue #403N 20877 United States or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien Electrical Engineer General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Jacob Wentz Emma Louise Klebo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Victoria Wood / Daughter 5306 Locust Avenue, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 24. ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Recurrent Aspiration Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year 4 Pregnant signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2; has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Registrar

20

Baltimore,

68760

Box (

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Sayed Elsayyad, 31. Date filed (Month, Day, Year)

D0062435

10110 Molecular Drive #206, Rockville, Maryland 20850

February 22, 2010

10-01589
Robert Wolff

lobert Wolff		State of	Maryland / Do	epartment d Ce <i>rtificate</i> d			Mental	Hygie		20	10	05358
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		- Incate (n Deau			2. D	Reg Date of Death	g. 140		3. Time of Death
√ledical Exami		Robert Charles	Wolff					F	nonth ebruary 2	Day Year 2, 2010		1420 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 210 Lower Magothy Beach Road 4c. County of Death Severna Park Anne Arundel										
		210 Lower Magothy Beach F			<u> </u>			41 Inc. To	Date of Digit			place (State or
Funeral Director		5. Social Security Number 6. Sex 216-42-4299 1X M		yrs. last birthday)	If Under Months	1 Year Days	If Under 24 Hours		5/25/	1 (MM/DD/YYYY)	Foreign	Maryland
Silector		Usual Residence of Decedent	₂ F 67	Y	rs.			_	7/23/	1342	Cou	nuy)
any		10a. State 10b. County	10c.	City, Town or Loc	ation						Т	10d. Inside City Limits
<u> </u>	ŗ	MD Anne Ar	undel S	everna	Park							1 Yes 2 No
daryland 28a-f show dat once.	Director	10e. Street and Number			10f. Zip C				10	g. Citizen of Wha	t Count	ry?
5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.												
th with ems 2	Funeral	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever Armed Forces?		/as Deceden Yes, specify					14. Race - White,		an Indian, Black,
er dea		3 Widowed 4 X Divorced If	Yes Give Year	No 1	Yes 2	Z No s	snecify:			Specify:	wh	ite
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d b	15. Decedent's Education (Specify only	Dates:		ent's Usual O	ccupation	n (Give kind		done	16b. Kind of Bus		
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most of work	ing life. D	O NOT use	retired)				
903(within iene. er tha	ompleted	12	0	Elec	troni					Contra	act	or
15-C filed v I Hygg ed oth	ပ၂	17. Father's Name (First, Middle, Last) Donald Wolff						•	st, Middle, M E • P	aiden Surname)		
21215-0036 July be filed within 7 Mental Hygiene, marked other than ic event, the Medical	To Be	19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address		_			er, City or Town	State,	Zip Code)
O & S & #		Dennis C. Mine	Brother	·- 652						sville,		1.0
ore, MEss 1 and 2 s of Health au If item 27		20a. Method of Disposition		20b. Place of Dispo		of ceme	tery,	Da	te	20c. Location - 0	City or T	own, State
Pages ent of nt: If		1 X Burial 2 Cremation 3 Donation 5 Other Specify:		Md. Vete		'emet	ery 3	/2/2	010	Crownsv	ille	e, Marland
20a. Method of Disposition Section Crownstille									Inc.			
		AN ON	- 2111							imore, M		
Physician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each	line.							st, snock, or near	۱]	Approximate Interval Between Onset and Death
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		Sequentially list conditions, b		,								
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=	хаш	(Disease or injury that initiated events resulting in death) Last	e to (or as a consequer	nce of):								
executed an and al - transit		d.									-	
D, be es	edical	▼ UNPENDED	MENDED 23a,	27, per 1	ME g90	1 3/	3/10	TT		Tage 8		
Box 6876(death certificate the attending physical for use as the b	N/M	23b. Was decedent pregnant in the	23c. If yes, outcome of 1 Live birth		etal death	3	Ectopic pre	egnancy		23d. Date of d Month	lel≇very Da	y Year
ox 6 th cer ttendi	icia	A T Man O T No O T Haliania	4 Pregnant at time	of death 5 (ther (Specif	(y)				846		
BO) he deatl y the att	Physician/M	Part II. Other significant conditions co	9 Unknown	not regulting in the	undadvina	ause aive	eo in Dart I	-	23e Did toh	pacco use contrib	ute to th	ne cause of death?
Division of Vital Records, P.O. Box the Hospital or Attending Physician: The law requires that the death hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attentietely filled in by the funeral director, page 2 should be detached for up	ğ	Tare in Outer Significant Conditions	initiality to death but	not resulting in the	di ideniying e	auoo giii	on mr unt					bly 4 🗸 Unknown
rds, P.C requires that been signed hould be deta	Completed							- III	24a. Was a			ppsy findings available
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tal Rection: The certificate ector, page		25. Was case referred to medical	<u>.</u>		26	Place of	f Death (Ch	eck only o	1 Yes 2	NO 1	Yes	2 No
Vital bysician: this certifi I director,	o Be		pital: 1 Inpatient	2 ER/Outpatie		In.				Residence 6	Other:	Scene
on of \ tending Phy eath. or: After the	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o	Injury 28	c. Injury	at Work?	28d.	Describe ho	ow injury occurre	d	
ion ttendi	atio	1 X Natural 5 Pending 2 Accident Investigation				1 Yes	s 2 No					
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Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the		4 Homicide	(Specify)					21	to the conse	(-) d		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	one) 2 ✓ Medical Examiner: On	To the best of my kno the basis of examinat									
To with Con	Med	29b. Signature and title of certifier	d manner stated.		29c.	License r	number			29d. Date signe	d (Mont	h, Day, Year)
		4 M	1.16			O.C.M.	.E.			February 23	, 2010)
		30. Name and address of person who com										
			ief Medical Exam		enn Street	, Baltin	nore, MD	21201	l 			
St Regist	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature hours								

				For State	State o	f Maryla		artment of l		and M	ental Hy	giene	0.1.0	050	
	Dharai	-:	,	Registrar 1. Decedent's Name (First, Middle	· ·		061				2. Date of De			3. Time of	Death
	Physic Med	dica	al	Edna 4a. Facility Name (if not institution.	R.			Warnic			Month 02	19	2010	09:00	рм
-R-4	Exam	nıne	er	2207 Mayfield Aver	9	iber)		4b. City, Town, o Baltimore		4c. County of Death					
I	Funer: Directo			5. Social Security Number 215-03-8113	6. Sex 1 ☐ M 2 🛛 F	7. Age (In yrs. 9 3		If Under 1 Year Months Days	If Under 2 Hours	24 Ĥrs. Min.	8. Date of Birt 1924/1				Foreign
	and show		ē	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation			1	0d. Inside Cit	y Limits		
	Maryl 28a-f		Director	MD N/A		Bal	timore		_		1 💢 Yes 2 □ No				
	vith the 23a or st be r		al	10e. Street and Number 2214 Corbin Avenue	2		10f. Zip Code 21214			_	0g. Citizen of What Country?				
	death vitems		- 1	11. Marital Status	12. Was Dece		Was Decedent of H	lispanic Origi	in? (Speci	fy Yes or No-	14. R	Race - American Indian,			
9000	urs after oural", or		ted by	1 Never Married 2 Marr 3 X Widowed 4 Divorced	ied 1 Yes If Yes, Give Year or Da	2 🔀 No		Yes 2 X No		ruerto Ri	can, etc.)	Spec	lack, White, e		
15-(72 hou in "nat Medica		Completed	(Specify only highe	t's Education st grade completed)		(Give	dent's Usual Occup kind of work done O NOT use retired)	during most of	of working	,	16b. Kind of	Business Inc	lustry	
212	y within ygiene.			Elementary/Seconday (0-12)	College (1-	4 or 5+)	Secreta	,				Electr	onics		
Maryland 21215-0036	ld be filed Mental H arked ot atic ever	P Elmer E. Heal							^{18.} Mother Edna	r's Name (First, Middle,	Maiden Surna V.	me)	Truma	n
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			19a. Informant's Name/Relationsh Heidi Green, Friend	ag Address (Street layfield Av	and Number enue, B	or Rural F altimo	Route Number	; City or Town 21213	, State, Zip C	ode)				
Baltimore,	tge 1 an ut of He			20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from	cemetery, cren	sition (Name of natory or other place		Da		20c. Location - City or Town, State				
altin	partme portan portan y injury	ě	ł	4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service Li		Pa	rkwood C	. Name and Addre		02/23/ I			iore, Mai Inc.	ryland	
m	5505 Hai Tol d Road, Baltillol e, PD 21214														
ı	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Betw Onset and De	een			
	Medica Examine	al		disease or condition resulting in death)	aDue to (c	or as a conseq		MTIA							
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_	cate be executed physician and the burial-transit		alical E	resulting in death) Last	Due to (c	or as a conseq	uence of):								
3760	ificate I ig phys as the	- 1 1	υ ⊢	E FENANCE.	d						.,_				
39 X	ath cert attendin for use		/ lall	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 Fet	al death 3 🗌	Ectopic pregnanc	у				Date of deliver		or I
P.O. Box 687	the dea by the a ached f		3	1 Yes 2 No 9 Unknown	4 ☐ Pregn 9 ☐ Unkno	ant at time of	death 5 L	Other (specify)					Month I	Day Ye	ar
O.	es that signed to be det	Manual Charles Charles Control of the Charles	Š	Part II. Other significant condition	ns contributing to de	ath but not res	sulting in the u	nderlying cause giv	en in Part I.			bacco use co	_		
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Records,	sician: The law i certificate has b lirector, page 2 s										autop perfor 1 Yes	med2		pletion of cau	
ita	sician: certific irector,	ď	ב ב	25. Was case referred to medical examiner?	Hospital:			Oth	ace of Death		nly one)		_	5 17510	1000
Division of Vital	ng Phy ter this neral d												11910	الدو ا	
sion	vttendii death. ctor; Ai y the fu	1	2 Accident Investigation M 1 Yes 2 No												
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Andiog	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										er stated.		
_	Vithi To the	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)													
		JUMBLY DMM) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Lilary DON M.D 5901 north Charles Street Baltimore Maryland										10			
				Hilary Don m	1.0 59		orth (Harles	Stree	et t	Saltin	nore 1	MAYY	LAND	
	St Regist	ate trar		31. Date filed (Month, Day, Year) FEB 2 4 20	10 Sen	gistrar's Sign	har	W							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 20°fb 04:50 n_M Mary White Margaret Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Genesis Eldercare Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 6 Sex 7. Age (In yrs. last birthday **Funeral** Days Min. 1 □ M 2 👿 F 0272971924 216-18-4239 MD Director Usual Residence of Decedent 28a-f show 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director Examiner must be notified 1 X Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral U.S.A. 21214 3116 Berkshire Road items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Yes 2 X No Yes, Give ŏ Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 White Yes 2 X No Specify permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fagan Walter, Sr. Marie Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Berkshire Road, Baltimore, MD 21214 William V. White, Jr., Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State any injury or Gardens of Faith 02/25/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Zandnasel 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause | each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any scale of the cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consuluence of Exami requires that the death certificate be executed ourial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IE FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnag 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 t 12 months 2 No Day Unknown Unknown Division of Vital Records, P.O. þ Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes cate has been siç page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to edical 26. Place of Death ___ck only one) Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ in by the funeral 27. Manne Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) the Hospital or Attending 5 Pending Natural 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not by Suicide 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determine City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Date signed (Month, Day, Year) 29b. Signature and title

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 24 2010

Dr. Gracito Patricio, M.D. 8903 Harford Road, Parkville, MD 21234

Registrar's Sig

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05361 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elizabeth Wall January 28,2010 0438 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Hospital Cheverly Prince George 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeal 941 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 68 579-56-9932 Director February 21. Washington DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macital Examinar must be notlined at 10a State ¥ Yes 2 No Director Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20602 United States 89 Garner Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent L. Armed Forces? 1 ☐ Yes 2 ▼ No Black, White, etc. 1 ☐Yes 2 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Private** Housewife Twelth None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Eugene Thornton Irma Dixon ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Wall/Husband 89 Garner Avenue, Waldorf Maryland 20602 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 4, 1 Burial 2 □ Cremation 3 □ Removal from State Heritage Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Waldorf, Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home Inc Donald R. Grav 1 1661 Good Hope Rd SE, Washington DC 20020 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications shock or eart failure. List only one cause Immediate Tay e (Final disease or c dition resulting in death) Metastatic lung Cancer **Physician** 2 yrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and Due to (or as a consequence of) burialphysician P.O. Box 68760 Physician/Medical the as attending IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the 9 ☐ Unknown 9 Unknown é Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑Ño 24a. Was an has page 2 s autopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in plete 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 20058213 munit 1/29/10 furhal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 Annapolis Rd Wenn Dale MD 20767 FARHAD JAMALI MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 24 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GRIGORIY YUFEST 5:32 AM 2010 Feb Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 5/14/1920 Country) UKRAINE Director 220-29-4867 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3601 FORDS LANE, #701 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🖁 No Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEER AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည YUFEST KHANA RIVA-HALEMSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KHANA YUFEST/WIFE 3601 FORDS LANE, #701, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■Burial 2 ☐ Cremation 3 ☐ Removal from State BALTO. HEBREW CEM. 2/21/2010 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Sign ture o Funeral Se 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease omplications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death s been signed by the service should be detached 9 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page 2 certificate l 1 Yes 2 No within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 2438946

State Registrar E university

32. Registrar's Signature

Parkway,

Baltimore

21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201

Cheikh

31. Date filed (Month, Day, Year)

Physicia		For State Registrar	State of Maryla	•	rtificate of		Reç	1. No.2 ()	0 05363
/Medic	an	Decedent's Name (First, Middle, La	Anna Mar	y Zawa	cki		2. Date of Death Month February	Day Yea 21, 2010	
Examin	_	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	or Location of Death		4c. County of De	
		FutureCare North	point			tpoint			more Co.
Funeral Director		218-01-1846	Sex 1 □ M 2)(F 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 26	(ear) 9. E 1916 Ma	Birthplace (State or Foreign Country) aryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar must be notified at once.		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo		Baltimore	City		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
e Ma-f s	cto	MD N/A							••
a or 2	ā	10e. Street and Number 150 N. Luzerne	Avenue		10f, Zip Code	21224	109	g. Citizen of What United	•
1s 23	era	11. Marital Status	12. Was Decedent Ever in	u.s. 13. 1			ecify Yes or No-		merican Indian,
", or iten	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	- 1	lf Yes, specify Cub 1 □ Yes 2 🙀 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, WI	hite, etc. White
naturai Scal E	Completed b	15. Decedent's E	Education	I (Give	dent's Usual Occu kind of work done	during most of work	ing 10	6b. Kind of Busines	
an "	ηdμ	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	nd)		0 ***	
it, ith		8 Years		Hot	memaker	10 Mathar's Nam	e (First, Middle, Ma	Own He	
ed of	ă	17. Father's Name (First, Middle, Las Joseph Germa					e (First, Middle, Mi Duisa	alden Surname)	unkn.
mari	၉ .	19a. Informant's Name/Relationship		19b. Mailir	na Address (Stree	t and Number or Ru		City or Town, State	e, Zip Code)
r trau		James J. Zawacki				ey Street			
or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [sition (Name of matory or other pla	ice) ¦		0c. Location - City	
Jury		4 Donation 5 Dother (Spec	eify) M.			er Cem. 2		Baltimo	
any In		21. Signature of Funeral Service Lice	ensee			ess of Facility Funeral Ave. Du			Inc. 21222
		23 art 1. Enter the disease, o or shock, or heart failure.	mplications that caused the d y one cause on each line.	eath. Do not ent	ter the mode of dy	ing, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
ician		Immediate Cause (Final disease or condition resulting in death)		DEME	NIM				
edical miner		resulting in death)	b. Due to (or as a cons	sequence of):	FATPHES	AI VAS	Caran	DILLEGIF	- 1
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons			-716 - 147		03236436	1
burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6						
ırıal-tı		resulting in death) Last	Due to (or as a con:	sequence of):					
the bu	Physician/Medical		d						
for use as the b	Me	IF FEMALE:	23c. If yes, outcome of pre	egnancy				23d Date of	dolivery
for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3	☐ Ectopic pregnan☐ Other (specify)	су		23d. Date of Month	Day Year
73	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	or dodding 5 L					
crie	급	Part II. Other significant conditions	contributing to death but not	resulting in the u	ndorlying cause g	iven in Part I.	23e. Did toba	acco use contribute	e to the cause of death?
e detached	>		_	0	inderlying cause g				Probably 4 Onknown
be detached	ed by		-		indenying cause gi		1 ☐ Yes	s 2 □ No 3 □	T TODADIY
should be detached	pleted by				indenying cause gi		24a. Was an	24b. Were	autopsy findings available to completion of cause of
should be detached	Completed by						24a. Was an autopsy perform	24b. Were prior death	autopsy findings available to completion of cause of
snould be detached	Be Completed by	25. Was case referred to medical examiner?	Howital				24a. Was an autopsy perform	24b. Were prior death	e autopsy findings available to completion of cause of
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After this certificate has been signed by the funeral director, page 2 should be detached	Certification: To Be Completed	examiner? 1	28a. Date of Injury - Abuilding, etc. (Sp	2 ER/Outpatie 2 Sb. Time of Injury At home, farm, streecify) knowledge, deal	nt 3 DOA Ot if 28c. Inji WC M 1 Creet, factory, office	her: 4 Nursing H	24a. Was an autopsy perform 1 yes 2 th (Check only one ome 5 Resider 28d. Describe how 28f. Location (Str. City or Town.	24b. Were prior death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e autopsy findings available to competion of cause of 1? Yes 2 Mo Specify) r Rural Route Number, or as stated.
s certificate has been signed by the director, page 2 should be detached	Medical Certification: To Be Completed	examiner? 1	28a. Date of Injury - Abuilding, etc. (Sp. Physician: To the best of my aminer: On the basis of exar and manner stated.	2 ER/Outpatie 2 Sb. Time of Injury At home, farm, streecify) knowledge, deal	nt 3 DOA Ot if 28c. Inji WC M 1 Creet, factory, office	her: 4 Nursing H	24a. Was an autopsy perform 1 yes 2 th (Check only one ome 5 Resider 28d. Describe how 28f. Location (Str. City or Town.	24b. Were prior death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e autopsy findings available to competion of cause of 1? Yes 2 Mo Specify) r Rural Route Number, or as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 12, 2010 9:04A Feb. Anderson Leonard Roy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Lake Park 607 L Street Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday Social Security Number **Funeral** Days Hours 1**X** M 2□ F 6/18/1928 South Dakota 81 Director 573-26-4858 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Wedical Evandance in the notified at 1 Yes 2 No Director Mt. Lake Park Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21550 607 L Street Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after Yes 2 2 🗆 No 1 ☐ Never Married 2 ☑ Married "natural", or Baltimore, Maryland 21215-0036 1 □Yes 2 No White ð 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Aircraft marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Aircraft Tooling Engineer Manufacturer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tedford Frances Martin Roy Anderson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s' if Health a 3849 Cove Road, Accident, MD 21520 Donna Stallings/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Countryside Crem. 2/15/2010 Davidsville, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. 179 Miller St., Grantsville,MD 21536 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications in a caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final yerr **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine aftending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, requires that the death certificate be Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No te has 1 ☐Yes 2 ☐ No 1 □Yes certifical Hospital or Attending Physician: within 24 hours after death.

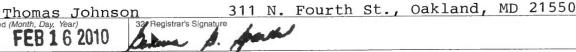
To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 TAccident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

d

31. Date filed (Month, Day, Year) **FEB 1 6 2010**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D15333

		1	For State Registrar	State of Maryland / Do	epartment of He		ntal Hygien		05365
			Decedent's Name (First, Middle, Last)			2	. Date of Death Month Da	ay Year	3. Time of Death
	Physicia		Hilda Viola Bowe	ers		F	ebruary l	.3 , 2010	5:30 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or	Location of Death	4	c. County of Death	1
			102 Resley Street		Hancock	If Under 24 Hrs. 8	. Date of Birth	Washing	ton place (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Days	Hours Min.	Month, Day, Year ugust30,1	r) Coi	Intry)
	Director	-	213-10-5601 Usual Residence of Decedent	95 Y		į.	ugustoo,i	714 1	A
700	Mo ti		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Man	Mary Mind	to	MD Washingt	on Hanco	ck				11X Yes 2 □ No
de de	or 28	Director	10e. Street and Number		10f. Zip Code			citizen of What Co	untry?
4	23e c	<u>a</u>	102 Resley Stre		21750			USA 14. Race - Ame	riego Indian
7	r dea	Funeral	11. Wanta States	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spec n, Mexican, Puerto R	ican, etc.)	Black, White	
ရှိ	nours arter dearn with the maryand turel', or Items 23e or 28e-f show al Exertiner must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1	1 ☐ Yes 2 🎇 No	Specify:		Specify:	White
3	stural stural	ed	15. Decedent's Educa	16a	Decedent's Usual Occupa	ntion	16b.	Kind of Business/	
<u>က</u>	within 72 ene. than "nai	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired)	1		_
7	giene grithe	E .	8	Sı	upervisor				nufacture
	be tile tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
<u>ya</u>	2 should be filed within 72 hours after dearn with the manyian and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-1 show aumatic event, if a Modical Examinating must be multified at	ဥ	Jacob Elmer Powell		Mailing Address (Street a		Alice Hep		Zip Code)
	12 sh h and 7 Is m Iraum		19a. Informant's Name/Relationship (Type Danielle Kann/Grand) Hannah Ct.				,
ď.	is 1 and 2 should of Health and Men item 27 Is marke other traumatic		20a. Method of Disposition		Disposition (Name of y, crematory or other place			Location - City or	Town, State
و	ages nt of t: # it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	y, crematory or other plac awn Mem.Park		/2010 Wil	liamsmor	t. MD
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or of once.		21. Signature of Funeral Service Licens		22. Name and Addres		41 West M		
Ä	Depa Depa Impo any is	2 15	Marie Salanda	JuM0026	GLOVE TUIL	ral Home,P	.A.Hancoo		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do n	not enter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	nysician	1	Immediate Cause (Final disease or condition	Congestive Hea	et Failure			3	Oriset and Death
	/Medical		resulting in death)	Due to (as a consequence of	of):				
	Examiner		Sequentially list conditions, b.	Due to (or as a consequence of	5f)·				
	ed sit	- Ju	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	51).				
	xecut and al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of	ol):				
760,	ires that the death certificate be executed signed by the attending physician and deedeched for use as the burial-transit	calE	L _d						
	ificate g phy as the								
Вох	death certifica e attending ph ed for use as th	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐Ectopic pregnancy	1		23d. Date of de Month	livery Day Year
	e deal	Physician/Med	in the past 12 months? 1 □ Yes = 2 ❷No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)				
P.O.	law requires that the as been signed by th 2 should be detache	Phy	Part II. Other significant conditions conf	tributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobaco	co use contribute to	o the cause of death?
က်	signe d be d	l by	Partin. Other signment contained con-				1 🗆 Yes	2 10 No 3 □ P	robably 4 Unknown
Ö	ne law require I has been sig ge 2 should b	Completed					24a. Was an	24b. Were a	utopsy findings available
Be	The lay ate has page 2	E G					autopsy performed 1 ☐ Yes 2 🔼	? death?	completion of cause of
<u>ta</u>	an: T tificate or, pe	Be Co	25. Was case referred to medical			26. Place of Death			
\leq	Physicien: r this certific ral director,	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Ou		4 Nuising Hor	ne 5 Residence		ecify)
0	ng Ph ter th neral	ü	27. Manner of Death 1 Natural 5 □ Pending		Time of 28c. Injury Wor	rk?	8d. Describe how in	njury occurred	
<u>Si</u>	Attending it death. ector: Atter by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be	20 80 (11) 20 415 20 60		Yes 2 □No	8f. Location (Street	t and Number or F	lural Route Number.
Division of Vital Records,	tal or Attending Physicien: The lav is after death. al Director: After this certificate has led in by the funeral director, page 2	Certification;	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	irm, street, ractory, onice	1	City or Town, Si		
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	ledical Ce	(Check only 2 Medical Examin	sicien: To the best of my knowledge ner: On the basis of examination an	e, death occurred at the tind/or investigation, in my o	me, date and place, a ppinion, death occurre	and due to the cause ad at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Pwithin 24 To the F	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. Licen:	se number	4	Date signed (Mon	
	5 2 5 8		1 / atchen	Halm MD	150	048	Fe	bruny 16	,2010
			30. Name and address of person who co		(Type, Print)	16	Marila	bruing 16 1 21750	-
	C	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	vania rvenus	, Hancel,	· way yeing	~ ~ · / \) V	
	Regist		FEB 24	2010 Emma	1. hadel				

DK.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

physician

Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral

/Medical

Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, the Medical Examiner must be notitied at 10a State ns 23a or 28a-f show must be notified at Funeral Director Marvland 10e. Street and Number þ Completed 17. Father's Name (First, Middle, Last) Be ဥ Earle Lynwood Browning/Husband 20a. Method of Disposition Department of Important: If it any Injury or o **Physician** /Medical **Examiner** Sequentially list conditions, if dry, leading to infried at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical attending pl 23b. Was decedent pregnant ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Completed page 2 s certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) 30469 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. B. VELL (AVK). 8850. CoLu H B70 PARKWAY + 308, Coliumbia 100 N.B. VELLANKI 8850, 32. Registrer's Signature 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001

a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** BR15 WE DEBORAH 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8923 GEORGETOWN ICENT COUNTY CHESTER TOLON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 □ M 2 X F 05-19-1958 219-76-9525 Maryland 51 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Md. Kent chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8923 Georgetown Road 21620 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Celeste Elementary/Secondary (0-12) College (1-4or 5+) Industries Corp. Assember 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence G. Freeman 2 Herbert Lee Briscoe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Briscoe/Father 8923 Georgetown Road, Chestertown, Md. 21620 20b. Place of Disposition (Name of cemetery, crematory or other page) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Chestertown, Md. Asbury UMChurch 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee Road 298, Chestertown, Md. 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4003 Due to (or as a consequence of): Kelves Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of): Examiner CURRENT Due to (or as a consequence of): waltmordisu Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Medical Certification: To Be Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

Examiner the death certificate be executed sician and burial-trans P.O. Box 68760, physician the as use ō signed by the a Division or Vital Records, page 2 certificate or Attending Physician: this within 24 hours after leath.

To the Funeral Director: After th completely filled in by the funeral

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

To the Hospital

State Registrar

305 A 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Dyfehmans lane 32. Registrar's Signature FEB 0 5 2010

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

046020

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Brian Cosgrove February 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) Jan. 21, 1961 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Min. 1 X M 2 □ F Hours Maryland Director 49 214-76-8926 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No <u> Maryland | Montgomery</u> <u>Germantown</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 Emerald Drive 20876 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or à 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Utility (Gas Company) Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic o Edward Vincent Cosgrove Elizabeth (NMN) Garvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Johnson Cosgrove, Emerald Drive, Germantown, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/7/2010 Alexandria, Virginia Signature of Fu eral Sen 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. F et the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if the rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Co. se Final Physician disease or con Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or) and Due to (or as a consequence of): resulting in death) Last attending physician at for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No the detached 9 Unknown P.O. by signed I Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform death? After this certificate funeral director, pag Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending n 24 hours after death.

Ne Funeral Director: Aipleted filled in by the fu death. М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24

To the Fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicole Evanuch, MD, 9901 Medical Center Drive, Rockville, Maryland 31. Date filed (Month, Day, Year) 20850 32. Registrar's Signature State

Registrar DHMH 17 Rev 7/2009 Leneun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 2:50 PM Motter Crapster Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Sunrise 8. Date of Birth (Month, Day, Year) 7 192 g, Birthplace (State or Foreign If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Min. 1 ★ M 2 □ F Mary Tand 88 Director 217-12-2275 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21701 609 Fairview United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

14 Yes 2 If Yes, Give Black, White, etc. orces: 2 NoWWII Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Department of Defense 12 Police Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John O'Neal Crapster Helen Reindollar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9017 Grape Creek Rd., Walkersville, MD 21793 John Todd Crapster / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 2/12/2010 Frederick, Maryland Mount Olivet Cemetery 4 Donation 5 Other (Specify) Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 outh 23a. Part : Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) UN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant a 9 Unknown Pregnant at time of death 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 performe 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕽 No 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 🗆 only one) 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Frederick, MD 21701

300 West 9th St.,

Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dilks February 4, 2010 Howard 4:10 a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 8394 Williams Drive Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**★** M 2 □ F Min July 28, 1942 Months Days Hours New Jersey 146-34-6773 67 **Director** Usual Residence of Decedent ad other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick **Maryland** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21704 USA be filed within 72 hours after death with 8394 Williams Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: If Yes, Give Specify. 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Engineering tech Nuclear Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Lawrence Dilks Hazel Cheeseman . Page 1 and 2 should ment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21704 Joyce Dilks - wife 8394 Williams Drive, Frederick, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 2-9-2010 Frederick, Maryland 4 Doppation 5 Other (Specify) 21. Sign we of Funeral Servic Pensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 IND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC TAMPONADE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MESOTHELIOMA WEEKS-METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Yes 2 No Unknown 9 Unknown Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🔲 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform After this certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Tes 2 No death. Investigation 6 Could not be hin 24 hours a er deat the Funeral Director 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical

20 +1 VA State Registrar

completed

29a. Certifier

only one)

30. Name and addre

3 🗖

TAIMUR

29b. Signature and title of certifier

SADAF

31. Date filed (Month, Day-Year)

of person who completed cause of death (Item 23a) (Type, Print)

MIT

. Registrar's Signature

MESCAND

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

arke

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

46Thomas Johnson Drive, Frederick, Maryland

29d. Date signed (Month, Day, Year)

02-03-2010

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0537 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 7:05 Dorothy Irene Dymond February 10, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Goodwill Mennonite Home Grantsville Garrett 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min Country) Pennsylvania 1 M 2 X F 215-34-4721 1922 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show 1 XYes 2 □ No Director PA Somerset Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 Gay St. 15558 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced "natural". White Completed Health and Mental Hygiene. em 27 Is marked other than "natura ther traumatic event, Its Modical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Manufacturer 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Andrew Housel Alberta Finzel ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. Shirley Kyle/Daughter 14900 National Pike, Frostburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 13, 2010 Salisbury, PA Salisbury Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to in modiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as # consectionce off Examiner burial-tran Due to (or as a consequence of): attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a, Was an has certificate 1 □Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, iours after death.

neral Director: After this certific filled in by the funeral director, I 24 hours a within 2 To the I

Dacem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad Naeem, 625 Kent Ave., Suite 204, Cumberland, MD

31. Date filed (Month, Day, Year)

FEB 1 6 2010

29b. Signature and title of certifier

29a. Certifier (Check only one)

32. Registrar's Signature

and manner stated.

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D006150

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 **Physician** 9, 10:04AM Feb. Marie Mabel Fike /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Accident 3511 Bear Creek Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/15/1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🖸 F Maryland 92 **Director** 220-34**-**1540 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Exprimer mast be muffled at once. 1 ☐ Yes 🏖 ☐ No Director Accident MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21520 3511 Bear Creek Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara ည Earl Bowser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Edmiston/Daughter 239 Maple St., Friendsville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/12/10 Accident, MD Zion Cemetery 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** minutes /Medical Due to (or as a consequence of): **Examiner** lu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Buczynski 32. Registrar's Signature 31. Date filed (Month, Day,

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of contriber

311 N. Fourth St. Oakland, MD 21550

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 8 2010 1:08 \mathbf{P}^{M} MARGARET K. GORMELEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT CORDOVA 11516 WOODWINDS COURT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 K F Months Days Hours NOV. 27, 1925 INDIANA 84 Director 317-22-7585 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2 YNo **CORDOVA** MARYLAND TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe "natural", or items 23a or Funeral UNITED STATES 11516 WOODWINDS COURT 21625 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces? þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry the M College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME HOMEMAKER 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ဂ္ ANNA GOREVITCH CHARLES KOPSEA t. Page 1 and 2 should be tment of Health and Mer tant: If item 27 is marke jury or other traumatio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1231 TYLER AVENUE, ANNAPOLIS, MD JAMES F. GORMELEY, JR./SON Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date MISHAWAKA FAIRVIEW CEMETERY 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or FEB.18,2010 MISHAWAKA, IN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 SOUTH HARRISON ST., EASTON, MD 2 21. Signature of Funeral Servi Licey L HOME, P.A. 21601 Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
- h-5 Immediate Cause (Final ercbrovascular Physician disease or condition Medical resulting in death) **Examiner** erten Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying and -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been siç e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate ha irector, page performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Tes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 02-09-2010

State Registrar

10 RS

555 Gruwood AV Easter MS 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar
DHMH 17 Rev 1/2001

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	4	For State	State of Ma	arytan			r nealli of Death			7111	0 0	5375
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/Medica		4a. Facility Name (If not institution, give		DARI	LENE HOB		n, or Location		mai	4c. County o		. 20 1
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Funeral		5. Social Security Number 6. S		e (In yrs.	last birthday)	f Under 1 Ye	ar If Under		e of Birth	ear)	9. Birthplace	(State or Foreign
Director		212-82-2043	□M 21\(\frac{1}{X}\)€	4	8 Yrs. 1	fonths Da	ys Hours	Aug.	of Birth nth, Day, Y	T961	Country) Maryla	nd
p ,	-	Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Local	ion	·				10d Ir	nside City Limits
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the M	ect	PA Adams 10e. Street and Number		гал	rrrera	10f. Zip Cod	Δ		100	. Citizen of WI		Λ
with	٥	165 Boyle Road					7320		.09	U.S.		
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. d other then "naturel", or items 23s or 28e-f show event, the Medical Examinar must be nutified at	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U	.S. 13. Wa	s Decedent	of Hispanic Or	rigin? (Specify Ye an, Puerto Rican, o	s or No-		- American In	dian,
or Iter	ב <u>ֿ</u>	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼 N If Yes, Give	No		es, specify C Yes 2⊠ !			etc.)		, White, etc.	
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aryla should ind Men marke umatic	٥	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Str	eet and Numb	per or Rural Route	Number, C	ity or Town, S	itate, Zip Code	в)
re, Maryla s 1 and 2 should f Health and Mer itiem 27 is merke other treumatic		Andrew Hobbs / Hu	sband		165 Bo	yle Ro	ad, Fa	airfield,	PA 1	7320		
or Health		20a. Method of Disposition		20b. F	Place of Dispositi cometery, cremat	on (Name of	place)	Date	20	c. Location - C	City or Town, S	State
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or any injury or other treumatic event, the Medical Everal once.		21. Signature of Furleral Service Licer	500	0	ROB	ame and Ad	dress of Facil	Y & SON	FUNER	AL HOM	ES, P.	Α.
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/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	,	100-1	/	P	· lust		
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Box 687(death certificate to a attending physical for use as the to a second control of the con	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			topic pregna	incy			23d. Date Mont	of delivery	Year
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5		30. Name and address of person who	completed cause of d	eath (Iter	n 23a) (Type, Pri	h (1 - 1 -	0 11 6	Radiona	0 21	101 6/0	d. de.	21215
9		31. Date filed (Month, Day, Year)	32. Register	r's Siana	Sina: H	Daly la	x 0/5	Menrin	C, C.	W.5.	CIVIALS A	THE MY
State Registra		FEB 0	9 20 10 32. Registre	Copidicans	D. A. 1	park	10					

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Hobbs, Pamela

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Maryland State Registrar		tificate of D			eg. No.	0 05076	
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Mary Helen Hostetler				2. Date of Death		3. Time of Death	
	Medic Examin	al	Mary Helen Hostetler 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	d	4c. County of Dea	0620 M	
كالمجاعد			W. MD Regional Health System		Cumber			Allegan	y Co.	
	Funeral Director		5. Social Security Number 216 18 1402 6. Sex 1 ☐ M 2 🖫 7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1/31/10	9. Bir 922 M	thplace (State or Foreign puntry) D	
	and show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Loc	ation				10d. Inside City Limits	
	Maryli 28a-f otifiec	irect		yersda					1 ☐ Yes 2 🔀 No	
	with the s 23a or lust be n	Funeral Director	10e. Street and Number 139 Spruce Hill Road		10f. Zip Code 15552	2	1	0g. Citizen of What Co USA	ountry?	
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	lf	Vas Decedent of His Yes, specify Cuban	n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W		
Maryland 21215-0036	thin 72 hou sne. than "nat ne Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4	(Give k life. DC	ent's Usual Occupa kind of work done do O NOT use retired)	ition uring most of workir	eg	16b. Kind of Business Hospital	Industry	
9	lled wil I Hygie other ent, th	Be	1Z 4, 17. Father's Name (First, Middle, Last)	INC	rse- RN	18. Mother's Name	(First, Middle, M			
ylan	should be fi h and Mental 7 is marke d raumatic ev	욘	Jacob Gnagey			Beu	lah Ber	nder		
Mar	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (Type, Print) Alexis Grew/daughter	1	-			City or Town, State, Zi Le,PA 155		
re,	1 and of Heal item 2		20a. Method of Disposition 20b. Pl	lace of Dispos	sition (Name of natory or other place	, D	ate	20c. Location - City or	Town, State	
Baltimore,	t. Page dment rtant: It		4 ☐ Donation 5 ☐ Other (Specify) Un1	on Cem	etery	2/15		Meyersdale		
Ba	permir Depar Impor any ir		21. Signature of Funeral Service Licensee CCO37	6 3	Name and Address	s of Facility W. Street, M	R. Price eyersdal	e Funeral l Le, PA 155.	Home, Inc. 52	
-	Physician	G X	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	i. Do not ente	the mode of dying	1	respiratory arres	st,	Approximate Interval Between Ons t and Death	
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P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 🗌	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	elivery Day Year	
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ivisio	I or Atten after deal Director: d in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)				28f. Location (Str City or Town,	reet and Number or Ru , State)	ıral Route Number,	
	n 24 hours n 24 hours ne Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: Dn the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.	
	To the within comp.		29b. Signature and title of certifier MD MD)	29c. License	number 0 66 15	<u> </u>	9d. Date signed (Mont	h, Day, Year)	
		5	30. Name and address of person who completed cause of death (Item Muhammad Naeem, 625 Kent Avenue			mberland,	MD 215	02		
	Stat Registra	te	31. Date filed (Month, Par Year) 6 2010 32. Registrar's Signature	ure d. A	pare					

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend item 5 per th g901 3-1-10 vt

State of Maryland / Department of Health and Mental Hygiene 2 0 1 1 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:05P M Feb. 8, 2010 Kitzmiller Eugenia Iona /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Garrett Dennett Road Oakland Manor Birthplace (State or Foreign Country) 5 Social Security Number 219— 216—26—3708 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 1 M 2 F Months Days Hours 70 Director 3/16/1939 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f shov ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Expaniest must be a cultified at 1 ☐ Yes 2 No Director Swanton MD Garrett 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21561 U.S.A. 511 New Germany Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify. Specify: White <u>ک</u> 3 √Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Entry 12 Data Processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Kauffman Brooks Harold Eugenia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a item 27 r other to St., Mt. Lake Park, MD 21550 Steven Kitzmiller/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Countryside Crem. 2/11/10 Davidsville, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. Kich Matte 203 S. Second St. Oakland, MD 21550 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 D Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Hoursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation nours after death.

neral Director: Al 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 crititying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hor To the Fune completely fi (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2110 D15333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson Fourth St. Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrage Signature

Registrar DHMH 17 Rev 1/2001

State

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 1- State #19a, FH, MD, TCHD, 2/41/40 PhaCertificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 3 Month Year **Physician** Richard 10:00AM Lane 2010 /Medical 4a. Facilify Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 500 Mai M HUFLOCK Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Hours 1**X**M 2□ F 09-06-1944 Director 211-32-4231 65 Mass Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Director Md. Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 South Main Street 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No \$ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cadmus than Elementary/Secondary (0-12) College (1-4or 5+) Electrician Journal Service marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Rayman ဥ Lane Cynthia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Collean L. Lane 500 South Main Street, Hurlock, Md. 21643 20b. Place of Disposition (Name of cemetery, crematory or other place)
Direct Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ BuriaL 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-03-201 ODOVER, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. 516 South Maine St., Hurlock, Md. 21643 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bacterial **Physician** month /Medical Due to (or as a consequence of): Examiner hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P

Division or Vital Records, P.O. Box 68760 Physiclan: this To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

funeral director, Certification: filled in by Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

215 Bloomingdale Ave Federalsburg W

31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month 2 **Physician** 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Garrett Oakland Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-26-19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min. 232-60-1584 1938 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. WV Tucker Funeral Director Canaan Valley 10e. Street and Number 10f. Zip Gode 10g. Citizen of What Country? BOX 2626C United States 70 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XÎNo Specify à Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Medical Transcription 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barton Wolford Viola Crossland Austin Vallie ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Z. Miller 70 - BOX 95 Davis Hubana 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State rsons City Cemetery 2-13-2010 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lohr+ Barb Funeral Home 21. Signature of Funeral Service Licensee 312 Main street - Parsons, W 26287 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** monuy disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) P.O. I certificate has been signed by the rector, page 2 should be detached? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 100M 24a. Was an autopsy performe 1 □Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yes 1 Dipatient 2 ER/Outpatient 3 DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation filled in by the fi 1 ☐Yes 2 ☐ No hours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

WV 26260 20c. Location - City or Town, State Parsons, Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 2010 255 N 4th St., Ste. 1, Oakland MD 21550

Year

2010

3:37

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

State Registrar 31. Date filed (Month, I

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month 11:35 P Hazel Florence McCusker 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Washington County Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🛛 F Months Days Hours (Month, Day,) March 29 Director 214-34-2215 76 Usual Residence of Decedent shov 10a. State 10b. County be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 28a-f 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 55 East Washington Street Apt.110 21740 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō δ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Mental Hygiene. narked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 r and Mental Joseph McClellan Divelbliss permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Carrie Alice Diehl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R.McCusker, Jr. / Son 1014 Clone Run Road Hedgesville, WV 25427 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn 02/15/2010 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, o shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest streng one caus, on each line. et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine nce of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a conseq nce of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 mont 1 Yes 2 No Dav Pregnant at time of death been signed by the should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 2 N Be 25. Was case referred to a 26. Place of Death (Check only one) Hospital: 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner eath 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work?
1 Yes 2 No Accident M Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie 29c. License number 36651 completed cause of death (Item 23a) (Type int)

Registrar's Signature

State of Maryland / Department of Health and Mental H

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Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Medical Exemine traust be notified at once.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - Reg. No. 2 0 1 0							00002				
		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day								V	3. Time of Death		
Physici Medio/		Leona Rebecca	a Pete:	rson					Februa		Year 2010	10:15 P ^M	
Examin		4a. Facility Name (If not institution				4b. City, Town, or	r Location o				ty of Death		
LAGIIII		Oakland Nursi:	ng & Rehal	o. Cente	r	Oakland				Garrett			
uneral		5. Social Security Number	6. S <i>e</i> x	7. Age (In yrs.		If Under 1 Year	If Under 2		8. Date of Birth	1	9 Birthn	lace (State or Foreign	
irector		077-20-6532	1 □ M 2 🗓 F	83	Yrs.	Months Days	Hours	Min.	(Month, Day 03/02/		NY	try)	
		Usual Residence of Decedent		0.0					03/02/	1,240	1 21 2		
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128	Director	10e. Street and Number		10f. Zip Code				10g. Citizen o	f What Coun	try?			
380		1504 Broadfor		21550				United	l Stat	es			
ns 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.						gin? (Spec	cify Yes or No-		ace - Americ		
重量	Ē	1 □ Never Married 2 □ Mar	Armed Formied 1 ☐ Yes			Vas Decedent of H f Yes, specify Cuba			Rican, etc.)	BI	ack, White, e	etc.	
0,1	by	3 X Widowed 4 ☐ Divorced	If Yes, G Year or D	ive Dates:	1	□Yes 2X No	Specify:			Spec	ify: Whi	te	
atri	Completed	15. Deceder	nt's Education		16a. Deced	lent's Usual Occup	ation			16b. Kind of	Business/Ind	lustry	
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T Ha	ρ	12	oomege (1 401 51)	Hom	emaker				Own	Home		
othe /ent,	Be (17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name	(First, Middle,	Maiden Suma	ame)		
ked	10 E	Paul Insler					Bess	sie	(un	known)			
ma	-	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	g Address (Street	and Numbe	er or Rural	Route Numbe	r, City or Tow	n, State, Zip	Code)	
27 is		Edward W. Pet	erson. Soi	n	1504	Broadfo	rd Rd.	. Oa	kland.	MD 215	550		
tem othe		20a. Method of Disposition	210011, 50			sition (Name of natory or other place		Da		20c. Location		wn, State	
Y OF		1 Burial 2 Cremation		State			i	00/10	10010			100	
njur		4 Donation 5 Other (5		Cun		d Cremate	_		/2010	Cumbe	erland	, MD	
Department of ream and monthly group. In items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Profical Examiner must be notified at once.		21. Signature of Funeral Service	1 .		22	Name and Addre David A 21 N. S	· Buro	dock	Funera:	l Home	P.A.		
		Katherine	7 Dweits	-							2155		
		23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that of the control one cause of the control of th	aused the death each lin <i>e</i> .				cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death	
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endii use	Z.	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna	incy	Ectopic pregnanc	24			23d. D	ate of delive	rry	
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by th ache	hys	9 ☐ Unknown	9 □ Unk	nown									
ned e det	Completed by Physicia	Part II. Other significant conditi	-		-	derlying cause give	en in Part I.		23e. Did to	bacco use co	ntribute to th	e cause of death?	
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shot	ete	/							24a. Was a	n 24h	Were autor	osy findings available	
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ficate r, pa		05 111							1 □Yes	2 🗗 No	1 ☐ Yes	2 □No	
certi	a	25. Was case referred to medica examiner?	Hospital:			t 3 DOA Oth			(Check only or				
this aldi	1	1 Yes 2 10 No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatien 28b. Time of		7 🗆 1401		ne 5 Resid			/)	
After	Certification: To	1 ☑ Natural 5 ☐ Pendir	ng (Mor	nth, Day, Year)	Injury	28c. Injur Worl	k?		8d. Describe h	ow injury occi	ırrea		
tor:	cat	2 Accident investi 3 Suicide 6 Could	not be				Yes 2 N						
Direc in by	ıt.	4 ☐ Homicide detern	ninger 286. Place	of injury - At no ing, etc. (Specif	me, tarm, stre	et, factory, office		28	81. Location (S City or Tow		nber or Rura	I Route Number,	
_ P		00 0 177											
<u>a</u> a	600	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								cause(s) and a fate and place	<i>m</i> ann <i>e</i> r as st e, and du <i>e</i> to	tated. the cause(s)	
Funera tely fille	3	anal , E Intomioni		ner stated.									
the Funera mpletely fille	Medica	one)				00-1:				00-1 D-11		D \(\alpha\\)	
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29b. Signature and title of certific		7/		29c. Licens	e number		2	29d. Date sign	-		
To the Funera completely fille	Medica	one)		7		29c. Licens	e number	301		_	ned (Month, I		
To the Funera completely fille	Nedica	29b. Signature and title of dentifie	er Mulium who completed cau			Print)	0618	801		2/	-		
To the Funera completely fille	Nedica	29b. Signature and title of certific 30. Name and address of person Ken R. Buczyn	who completed cau	311 N	. 4th S	PO	0618	<i>(0 </i> id, MI		2/	-		
To the Funera completely fille	5 te	29b. Signature and title of certific 30. Name and address of person Ken R. Buczyn 31. Date filed (Month, Day, Year)	who completed cau	311 N	. 4th S	Print)	0618	60 / nd, MI		2/	-		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Ernestine May Rippeon February 6, 2010 8:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine Kline Hospice House Mount Airy
If Under 1 Year | If Under 24 Hrs. Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Days Hours 218-82-5937 Director 95 1914 Maryland Sept. 11, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shevent, the Medical Examiner must be notified Director 1 ☐ Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Funeral 7046 Catalpa Road 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Ith and Mental Hygiel

7 is marked other the traumatic event, In-Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest B. Ballenger Lilly Mae Kinna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any Injury or other troone. Peggy Brandenburg, daughter 25620 Frederick Road, Clarksburg, Maryland 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Mount Olivet Cemetery 2/12/2010 Frederick, Maryland 21. Signature of Juner 22. Name and Address of Facility Molesworth-Williams Funeral Home waw o 26401 Ridge Road, Damascus, Maryland 23a. P. 11. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Imme tiate Cau e (Final diseas or condition resulting dear) Physician colon MO5 cancey /Medical Due to (or as a consequence of): Examiner Granary or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cons, quence of) Examiner The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a P.O. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen certificate has b irector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 1 □Yes 2 X No 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: $_{4}$ \square Nursing Home $_{5}$ \square Residence $_{6}$ \square Other (Specify) \square Hopice 1∐ Yes 2 XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. iours after death.

Peral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital To the Hospital within 24 hours a To the Funeral Completely filled 29a, Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

D.0

address of person who completed cause of death (Item 23a) (Type, Print) apoi

32. Registrar's Signature

Denjamin

31. Date filed (Month, Day, Year)

458132

Main St

8

#208 Damascus MD 20872

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Amended #19a perFH FCHD KS 2/9 Certificate of Death 3. Time of 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ М BRU 2010 03A STANLEY EUGENE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours Min. Months 945 Pennsylvania 64 September . Director 164-42-3284 Usual Residence of Decedent show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director 1 Yes 2 No Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò "natural", or items 23a or Funeral 1900 Rosemont Avenue 21702 USA Page 1 and 2 should be filed within 72 hours after death ament of Heatth and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Retail sales Salesman 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) son 108 Edinburgh Court, Walkersville, Maryland 21793 Joseph L. Rogers - won 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Termation 3 Removal from State 2/9/2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Mes 23a. Part 1 Enter the disease or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Due to (or as a consequence of). Medical Examiner Secure tially list over ditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pate has I autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 3 1 Depatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed

After thi funeral Certificate: Natural death. 2 Accident
3 Suicide
4 Homicide

Medical

29a. Certifier

(Check

only one)

3 🗆

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

n 24 hours after death.

The Funeral Director: A pleted filled in by the funeral pleted filled сотріеть

Division of Vital the within To the

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen

Investigation 6 Could not be

determined

32. Registrar's Signature ENEUA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

2 🗆 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D60417

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year,

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FEBRUARY 2010 Physician/ 8:55A CATHERINE SMITH Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Feb. Pay, Y Year 919 Hours 1 M 2 T Mary Tand 214-28-7285 Director Usual Residence of Decedent and Mantal Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Frederick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 Funeral U.S.A. 608 Charles Street Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes ⋧ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Ethel Stull Roy Stull traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health ar Important: If item 27 is any injury or other trau 608 Charles Street, Frederick, Maryland 21701 Terry Ridenour / Granddaughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Frederick, Maryland Resthaven Mem. Gardens 2/9/10 4 Donation 5 Other (Specify) 21. Sign we of Ineral Service L ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. as NORTH MARKET STREET. FREDERICK. Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? page 2 s performed' 1 ☐ Yes 2 ☐ No Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 1 Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: injury work' 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death.

I Director: A
od in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hin 24 hours after the Funeral Dire mpleted filled in b Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2.

To the F only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who comply

Sajjad Aziz M.D

31. Date filed (Month, Day, Year)

ted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Chrone

House

801

09

Toll

D58391

Frederick Md. 21701

2/3/2010

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Year Month Day SHRY 2010 40 JUDY BURDETTE Februar Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 D M 2 DXF Months Days Hours Min. 67 1942 Maryland 215-42-3371 Director June Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Frederick Woodsboro 1 Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21798 11622 Woodsboro Creagerstown Road Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black White etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18 Mother's Name*(First, Middle, Maiden Surname)* Elizabeth Miles ပ William E. Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11622 Woodsboro Creagerstown Rd., Woodsborogs MD f Health a item 27 i Carroll Shry / Husband 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 2/9/2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Part *. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. 23a. Part . Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final .∮nysician/ ardi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be in 24 hours after death.

the Funeral Director; After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2. No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funer

completed file (Check 29b. Signature and title of certifier 29c. License number 3 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 10200 Coppermine Road Woodsboro, Maryland 21798 Gene F. Ashe, M.D32. Register's Signature 31. Date filed (Month, Day, Year) State Russian Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar 05387 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month REGINA FLANIGAN SHANNAHAN February 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospita Easton Talbot Memoria If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours 2/3/1917 MARYLAND Yrs Director 217-28-4646 93 Usual Residence of Deceden 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral shannahan, Regina with t 117 EAST DOVER STREET, APT. 202 21601 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates WHITE 3 Widowed 4 X Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 COMMUNITY LEADER HISTORIC PRESERVATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN LEG FLANIGAN MARY E. VON HAGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau MARY CAROL SHANNAHAN/DAUGHTER 5151 ULMER ROAD, ROYAL OAK, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/13/2010 OXFORD CEMETERY OXFORD, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCER Z. 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) He J te mornha Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Durity for as a consequence of: Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the burial Physician/Medical that the death certificate be P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, been signated the 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed? Yes 2 certificate l Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital ျပ 1 Dopatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 RS DENNIS M. DESHIELDS 219 SOUTH WASHINGTON STREET, EASTON, MD 21601 31. Date filed (Month, Day Year) FEB 0 9 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LEROY DAWSON SADLER FEBRUARY 2010 12:00 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TALBOT 21560 CHICKEN POINT ROAD TILGHMAN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Months Hours MARCH 10,1921 MARYLAND Director 88 212-18-6425 Usual Residence of Decedent Show and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND TALBOT TILGHMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21560 CHICKEN POINT ROAD 21671 UNITED STATES filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Never Married 2 Married þ 1 X Yes If Yes, Give 2 No 1944-Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify.WHITE Completed 1946 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) COMMERCIAL Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the WATERMAN FISHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be GUSTAV SADLER RUBY LEDNUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or any PHYLLIS SADLER/WIFE 21560 CHICKEN POINT ROAD, TILGHMAN, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other plant TILGHMAN MEMORIAL CRMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) FEB.17,2010 TILGHMAN, MARYLAND 21. Signatura | Fuperal Servix Ligar 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON ST., EASTON, MD 2 235. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 100 Physician/ disease or condition mas Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oil) attending physician and for use as the burial-transit certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? No death? certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 WNo မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month

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Easton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schr

02-08-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4:58 M Month February 07, 2010 **Physician** Alta Marie Schramm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg Frostburg Village Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 22, 1924 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Days Ohio. 85 Director 277-30-2284 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar mast by multified at 1 X Yes 2 ☐ No Lonaconing Directo Maryland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature" any injury or other traumatic accessions. 21539 1 C Pershing Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify White \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve Pindle Walter Algoe ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19913 Westerly Avenue, Poolesville, Maryland, 20837 Charles Schramm - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date February 12 20a. Method of Disposition Moscow Mills, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Eichhorn-McKenzie Funeral Home P.A 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lonaconing, MD 21539 8 East Main Street 1soma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DRONAM **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) s been signed by the a should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Loknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy perform this certificate 2 DHe 2 No 1 ☐Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 ☐ Accident 5 Pending ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 7:45 PM **Physician** 7, 2010 February R. Secrist Melvin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Kitzmiller 1366 Shallmar Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Hours Days 1 M 2 □ F 05/11/1950 WV 220-52-7692 59 Director Usual Residence of Decedent 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10h County item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, IT = Wellcal Examination and a confidence at 1 ☐ Yes 2X No Director Kitzmiller MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 1366 Shallmar Road 21538 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 □ Yes 2 No Specify. Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be to Department of Health and Merimportant: If them 27 in any Injury or contract. Ida Pearl Brown Secrist Virgil ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1366 Shallmar Road, Kitzmiller, MD Sharon Secrist, Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 02/11/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home 710 Church St., Kitzmiller, M 21. Signature of Funeral Service Licensee Katherine Sucitor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final taxie VCIWOUGO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 100 hast page 2 1 ☐ Yes certificate director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After the 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

311 N. 4th Street, Oakland, MD 21550 Robert A. Goralski,

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

29c. License number

D23979

29d. Date signed (Month, Day, Year)

02/08/2010

Please Type or Print in Black Indelible Ink, Ensura All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ 1310 M <u>Thompson</u> Dixie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Ohio **Funeral** (Month, Day, Ye Sep 14 1 □ M 2 □ F Months Hours Director 218-16-4291 85 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 801 Fayette Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces þ 1 Never Married 2 Married 2 **X**No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>homemaker</u> own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louiso H.-(Rafter) (Gough) Rafter John V . Rafter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 National Highway LaVale MD 21502 daughter Dinah Searles Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Memorial Park 2/22/2010 MD Cumberland 4 Donation 5 Other (Specify) Signature of Euneral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Week Immediate Cause (Final Physician FAILULE disease or condition resulting in death) TAGE Medical Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

FEB 24

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 7:30 P M Nina J. Wehr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis College View Center Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 25, 1941 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Washington, DC Director 68 578-54-7848 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director Frederick 1 X Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 21702 2501 Coach House Way, Unit 1-D United States "natural", or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces ò 1 Never Married 2 Married ☐ Yes 2 🛣 No Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည Richard Whalen Nina Andrews traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is lury or other tra 2501 Coach House Way #1-D, Frederick, MD 21702 George F. Wehr / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Frederick, Maryland 21. Signature of Fineral Service Lic. see Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cryptogenic Cirrhosis disease or condition resulting in death Medical Due to (or as a consequence of) Examiner Hepatic Encephalopathy Sequentially list conditions Examine Dille to for as a consecutence of cause. Enter Underlying Cause (Disease or iinjury physician and s the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 X No 9 Unknown 4 ☐ Fregnant 9 ☐ Unknown ed by the a P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [출 law requires Division of Vital Records, cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hospital or Attending Physician; The I 24 hours after death. certificate 1 Yes 2 No Yes 2 X No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this nin 24 hours after death.

the Funeral Director: After thi
npleted filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 7/2009

State

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To the I

complete

(Check

29b. Signature and title

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31. Date filed (Month, Day, Year)

a Certifier

Sibte Kazmi, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 St. I ELAND.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Or Kant

814 Toll House Ave. Frederick, MD 21701

29c. License number

D 47951

29d. Date signed (Month, Day, Year)

February 4, 2010

Physician /Medical Examiner Funeral Director	1. Decedent's Name (First, Middle, Last) ANTONIO 4a. Facility Name (If not institution, give						- C U	- U -	
/Medical Examiner Funeral			į.			2. Date of Dea Month	ath Day	Year	3. Time of Death
Funeral	4a. racility Name (ii not institution, give :	ALLEN				FEBRU	ARY 15	2010	4:00PM
runerar	HARBOR H	USPITAL		4b. City, Town, or BAL	TIMU		4c. County	of Death	
Director	Social Security Number 6. Sex	14 OF F	**	If Under 1 Year Months Days	If Under 24 I		h v. Year)	9. Birthplac	ce (State or Foreign
	214-82-1873	M 2□F 46	6 Yrs.	Weiling Baye		May 27	, 1963	Mary1	
yland	10a. State 10b. County	10c. City,	Town or Loc	ation				10d	. Inside City Limits
vith the Mar or 28a-f sl be notified Director	MD		Ва	ltimore					1¶TYes 2□No
with the	10e. Street and Number 4515 Pennington A	venue 3rd flr		10f. Zip Code	1226		10g. Citizen of W	hat Country JSA	?
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exx., it are must be notified at eted by Funeral Director		2. Was Decedent Ever in U.S.		las Decedent of H	ispanic Origin?	(Specify Yes or No-		- American	Indian,
ors after	1 Never Married 2 Married	Armed Forces? 1		Yes, specify Cuba ☐Yes 2∏No	n, Mexican, Pu Specify:	ierto Hican, etc.)		, White, etc	
hours itural	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates:		ent's Usual Occupa			16b. Kind of Bus	blac	
ed within 72 hou lygiene. ner than "natura ft, fr. Modica E Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give k	ind of work done of NOT use retired	furing most of v	working	TOD. TAING OF BUS	onie savinaus	unk unk
Hygien Hygien other th.	12	0	ca	rpenter					
d be fill sed off c even	17. Father's Name (First, Middle, Last) Wilbert Gladdey					Name <i>(First, Middle,</i> :ta Shaver		•)	
2 should be and Mental is marked or raumatic every	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Mailing	Address (Street a		Rural Route Numbe		State, Zip C	ode)
and 2 ealth a n 27 is	Darnetta Shavers/	mother				altimore,			,
o i i i	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R			ition (Name of atory or other place	e)	Date	20c. Location - 0	City or Town	, State
mer ant ury	4 Donation 5 State (Specify)	in state Che	sapeak	e Crem.	3-1	1-10 D. Lohrma	Beltsvi	lle, M	ſd.
Depa Impo any ir	21. Signature of Funeral Service License W	ade, Director	12.0	ete anate	my buc		Green Pa	re St asture	reet es Dr.
	23a. Part 1. Enter the disease, or compton shock, of heart failure. List only on	cations that caused the death.	Do not ente	ltimore , r the mode of dying	g, such as card	7111		A	pproximate iterval Between
Physician	Immediate Cause (Final disease or condition		RRH	AGIC	ST	ROKE		0	8 FICURS
/Medical Examiner	resulting in death)	Due to (or as a conseque	nce of):						
je je	Se uentially list conditions but any, leading to immediate	Due to (or as a conseque		NSION	<i>J</i>				
n and ial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events								
	resulting in death) Last	Due to (or as a conseque	nce of):						
g physicial as the bur	d			-					
d by the attending pletached for use as I	23b. Was decedent pregnant	Bc. If yes, outcome of pregnand		F-4			23d. Date	of delivery	
by the att tached for	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Mon	th Da	ay Year
ed by detach	9 ☐ Unknown Part II. Other significant conditions com		ing in the un	farlying cause give	n in Part I	23a Did to	bacco use contri	buta to the	cause of death?
es registration of the second				.ony.ing sadoo givo	THE CALL IT				iy 4 🔀 Unknown
cate has been s page 2 should						24a. Was a		ere autopsy	y findings available
						– autop: perfor 1 ∐Yes	med? de	rior to comp eath? □Yes 2 l	letion of cause of □No
Attending Physician: rdeath. ector: After this certific by the funeral director. ification: To Be C	25. Was case referred to medical examiner?	nomital:				Death (Check only or	ne)		
La	1 Yes 2 No □	ospitał: 1 ☑ Inpatient 2 ☐ EF	R/Outpatient 8b. Time of	3 ☐ DOA Othe	r: 4 ☐ Nursing	Home 5 Resid	ence 6 Othe	r (Specify)	
ath. r: After e funera	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work	? ′es 2 □ No	Zou. Describe n	ow injury occurre	u	
rs after death. al Director: After led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (S City or Town	treet and Numbe	r or Rural R	oute Number,
illed ir	00- 0								3
in 24 hou he Fune pletely fi	29a. Certifier (Check only one) 1 ☑ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my knowle er: On the basis of examinatio and manner stated.	edge, death in and/or inve	occurred at the time estigation, in my op	ne, date and plant pinion, death or	ace, and due to the o courred at the time, o	cause(s) and mar date and place, a	nner as state nd due to th	ed. e cause(s)
	29b. Signature and title of certifier			29c. License	number		29d. Date signed		y, Year)
	> Adusamilli	MD		RES	000	1 F	EBRUAR	4 15	2010
	30. Name and address of person who con		3a) (Type, P	rint)	ER S	TREET	-		
200	31. Date filed (Month, Day, Year)	32. Registrar's gnatur		BALTI	MORE	TREET	AND,	210	125

DHMH 17 Rev 1/2001

amendtate of Maryland & Bepartment & Phealth and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Charles Anthony Adams February 2010 9:28 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6610 O'Donnell Street Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye July 25, 5. Social Security Number 7. Age (In yrs. last birthday, Year) 1957 **Funeral** Days Hours 1 X M 2 □ F Maryland 213-70-3017 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment number rotified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6610 O'Donnell Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white Specify. ۾ Specify. 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madge Cornette Letcher ADams ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6610 O'Donnell Street Baltimore, MD Lisa Niziolek/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ O Chesapeake Crem 3-1-10 Beltsville, Md. 22.NCAFA/ddStephen D. Lohrmann, PA Director 8717 Green Pastures Dr.21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ac **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dim to (or as a nonsecumno of) attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Řecords, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached f 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No ➤ Probably 4 ☐ Unknown ours after death. erel Director: After this certificate has been si filled in by the funeral director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 □ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) Medical Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Funel

completely fil 29a. Certifier 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 29c. License number INTERNUT DLE 8105 31. Date filed (Month, Day, Year) 32. Registrar's State FEB 25 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Day **Physician** Marie Ball /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1130 El Dorado Drive Lusby If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 22054 2217 10/31/1930 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural" or item. any Injury or other trainment. 10b. County 10c. City, Town or Location MI Funeral Director Lus WD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2065 1130 arado 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 El Dorado Drive, Lusby, MD 20657 Gina Ball / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/24/2010 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only in cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the dripping Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death

20c. Location - City or Town, State Hanover, Maryland 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 26. Place of Death (Check only one Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Merrinac Cf

Rea. No.

2010

Calvert

Japan

ASIAN

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

2. Date of Death

eral Director: A hours after death within 24 hours a

To the Funeral C

completely filled

Division of Vital Records,

State Registrar

ģ

Completed

Be

Certification: To

Medical

25. Was case referred to medical

Name and address of person who co

5 Pending

investigation

determined

6 ☐ Could not be

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

DHMH 17 Rev 1/2001

ORIGINAL

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

pleted cause of death (Item 23a) (Type, Print)

238

28b. Time of

28c. Injury at Work?

28a. Date of Injury (Month, Day, Year)

and manner stated.

Noble my

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 05396 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 0100M 2010 ehrva /Medical 4a, Facility Name (If not institution, give street and number 4b. City Town, or Location of Death County of Death Examiner 5 DWN TIMOVE thwes ente f Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Hours Months Davs 1 □M 2 □ F 213-06-6 26 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State id other than "natural", or items 23a or 28a-f show event, the "Medical Expressions", ust be retified at 1 Nes 2 No Funeral Director moul 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ∏ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Malden Surname) Father's Name (First, Middle, Last) Health and Mental ပ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
once. Johnson - Mother Baltimore Montressa 20b. Place of Disposition (Name of cemetery, crematory of other Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signatur Funeral Service Lice towell 22. Name and Address of Facility Balto MD 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 KER/Outpatient 3 DOA 1 Inpatient After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 ☐ Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier Attante and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

EB 25 2010

32. Registrar's Signatur

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		Registrar Decedent's Name (First, Middle, La	nst)				<i></i>	Julii		2. Date of D Month	eath		3. Time of De	eath
Physicia /Medic		-Charles Warren B	lack C	harle	s Wa	rren B1				Februa		3 ^y 2010	10:55	A M
Examin	er	4a. Facility Name (If not institution, gi				4b. City, Tow		cation o	of Death		40	c. County of Dea		
Funeral		1131 Gypsy Lane 5. Social Security Number 6.		e (In yrs. las	t birthday)	Towso	ear If	f Under		8. Date of B	irth	Baltimo 9. Bir	thplace (State or F	oreign
Director		218-28-4971	1 X M 2□ F	81	Yrs.	Months Da	ays I	Hours	Min.	8. Date of B (Month, I July 2	av veat	1928 Mar	ÿland	
pud ★		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation			-				10d. Inside City	Limits
Maryla f sho	lor	MD Baltin	10.20	, see eng,	Tow								1 □ Yes 2	No No
r 28a	irec	10e. Street and Number	1016		100	10f. Zip Coo	de				10g. C	Citizen of What Co	untry?	
filed within 72 hours after death with the Maryland Hygiene. Hygiene. the wasteal show the than "natural", or items 23a or 28a-f show ent, the Madical Evanteer must be notified at	Funeral Director	1131 Gypsy Lane	West				2	1286	5			USA		
tems	une	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Vas Decedent f Yes, specify (of Hispa Cuben, I	anic Ori Mexicar	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit		
rs afte		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1	l∐Yes 2X∑	No 5	Specify:				Specify: W	hite	
2 hou latura	Completed by	15. Decedent's E	ducation		16a. Deced	dent's Usual Oc	ccupatio	on	t of work	ina	16b.	Kind of Business	Industry (
ithin 7 ne. nan "r	nple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work do		nig mos	i or work	ng		c 1 ·		
lled w lygier ther th		12 17. Father's Name (First, Middle, Las	3		vice	presid		R Mothe	ar's Name	First Middl	e Maide		ndustry	
d be f ental l ked ol c eve	o Be	Charles Warren				18. Mother's Name (First, Middle, Maiden Surr Alice Maxwell								
shoul	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street								al Route Num	ber, City	or Town, State,	Zip Code)	
and 2 ealth a n 27 ls		Warren Black/son 211 Coldbrook Road Timonium, MD 21093										_		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If time 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ce of Dispo netery, cren	sition (Name o natory or other	of rplace)			Date	20c. l	Location - City or	Town, State	
t, Pag rtmen rtant: rjury		4X Donation 5 ☐ Other (Special	fy)		100	No.	-1-1	-6.502			<u> </u>			
permi Depa Impo any ir		21. Signature of Funeral Service Lice RONALD S	Wade / Dir	ector	St	. Name and Ada ate Ana	atom	ny B	oard	655 W	. Ва	1timore	Street	
		23a. Part 1. Exter the disease, ir con	nplic flons that caused	the death.		.1timore erthe mode of					arrest,		Approximate Interval Betwe	non.
hysician	y: 3	shock, or heart failure. List only	one cause on each li	ne.		co. tic	,		~				Onset and De	ath
/Medical		disease or condition resulting in death) a. Metastatic garceatic (and pure final disease or condition resulting in death) Due to (or as a consequence of):												
Examiner	_	Sequentially list conditions,	b											
ted Tsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):									
executed an and rial-transit	Exar	that initiated events resulting in death) Last	C. Due to (or as	a conseque	nce of):									
ficate be ex physician s the burial.	ical	•	d											
entifica ing ph e as th	Med	IF FEMALE:												
leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	leath 3	Ectopic pregr						23d. Date of de Month	livery Day Y e	ar
that the de ned by the a detached t	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of dea	atn 5L	Other (specif	ry)							
to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. The service is completely filled in by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.		Part II. Other significant conditions	contributing to death b	ut not result	ing in the u	nderlying cause	e given i	in Part I		23e. Did	tobacco	o use contribute t	o the cause of dea	ath?
en sig	Completed by	hypertens	01000							1 🗆]Yes	2 □ No 3 □ F	robably 4 Un	known
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sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Other:			h (Check only				
g Phys er this eral di	ı: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ıry 2	8b. Time of	1t 3 □ DOA 28c.	Injury a	4 L IV	ursing Ho	28d. Describe		6 ☐ Other (Spi jury occurred	ecify)	
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I or Attendi after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not determined		ury - At hom c. (Specify)	ne, farm, str	eet, factory, off	fice			28f. Location City or T			ural Route Numbe	er,
pital c		29a, Certifier 1 Certifying F	hysician: To the best	of my know	lades dost	h occurred at t	the time	dato	nd place	and due to th	20 031100	a(e) and manner	as stated	
To the Hospital or Attending Physician: The law requires tha thin 24 hours after death and the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be det	Medical		miner: On the basis of and manner st	of examination										
Verithin to the complete the co	Me	29b. Signature end title of certifier				29c. Li	icense n	number				Date signed (Mon		
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		30. Name and address of person who		death (Item 2		1		111	011	0.1		(1 - 1)	C, M.O	
Sta	te	31. Date filed (Month, Day, Year)	2. Registi	rar's Signatu		anda	7	2/2	04	rain	or, o	unald	1, M.O)
Registr		FEB 25 201	O Senara	rars Signatu	for	Col								
			1		-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15, **Physician** FEB. 2010 4:30 РМ CHARLES BOBO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MIDLE RIVER IVY HALL NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | DEC. 19, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F 88 Yrs. UNKNOWN 236-20-9885 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 € No Directo BALTIMORE MD **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 1125 OLD EASTERN AVE APT B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry should be filed within and Mental Hygiene. • marked other then Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN UNKNOWN UNKNÓWN permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if Item 27 ie merked oth eny injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN UNKNOWN ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code BALTO., MD 21202 TERRY SULLIVAN-GUARDIAN OF PROP. 10 N. CALVERT ST SUITE 200 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/19/10 importent: if eny injury o once. GARDENS OF FAITH BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) e of Fundal Service Licensee 21. Signat 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 8 23a. Rant / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Complications of Right /Medical Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as t IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificete has b irector, page 2 st 24a. Was an DIOTI autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Accident
3 Suicide 1 ☐ Yes 2 No tal investigation 281. Location (Street and Number or Rural Route Number, City or Town, State) 360 Wind Lass Rd Middle River, MD 21220 6 Could not be determined NUTSING Home

Middle River MD 212

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician: within 24 hours after death To the Funeral Director; completely filled in by the To the

02/15/2010 1630

Bobo

Harles

Maryland 21215-0036

Baltimore,

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day; Year) 32. Re

30. Name and address of person who completed cause of death (Illem 23a) (Typel Print)

110

Trimble Hill CT Litherville, Md 21093

DHMH 17 Rev 1/2001

29c. License number

18667

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh g900 2-25-10 vr. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** February 22,2010 James 1am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner nery land General OSPI-tal actimere 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 38 South If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Min Months Days Hours 251-62-0115 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 1∩a State 10c. City, Town or Location "natural", or items 23a or 28a-f shov Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Funeral Director Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by Blac 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19b Mailing Address (Street and Number or Rural Route Number of Road -19a. Informant's Name/Relationship (Type. Print) (Sister) City or Town, State, Zip Code) We lae Wood Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State unsdowne, Md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Loseph L. Russ Funeral Home, P.A.
2222 W. North Ave. Balto Md. 2 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Spiratory Syndrome **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or s a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Duff (or as a consequence of): attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical tailure IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 2 □No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hecident erebrovascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rough lace MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,D Sunlas 32. Registras Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month February 1346 PM 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FI LES VI I If Under 1 Year If Under 24 Hrs. Homore 6 Sax 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 M 2 N F 94 Yrs. Korea Director None Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Nes 2 No Resville Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 6 Korea Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Yes 2 Ne Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Asian þ Specify. Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre s (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau SWIT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Filmeral Service Licen 22. Name and Address of Facility Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed use as the burial-transit Examir Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ġ Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗌 Unknown à ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an this certificate has autopsy performed? 2 No 1 Yes of Vital After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 2 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Matural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rimble 31. Date filed (Month, Day, Year) 32. RegisIrar's Signature

DHMH 17 Rev 1/2001

Registrar

FEB 25 2010

81/20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 **Physician** 1115 John Casper Carnes 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number Hospita N/A Bultimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, 1933 9. Birthplace (State or Foreign Funeral 1 ★ M 2 🗆 F Months Days Hours Maryland 77 Director 215-28-9167 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1X Yes 2 □ No N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 1150 Cleveland Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1957- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 🕱 No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Laborer Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Carnes Cora Griffith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important; If item 27 is
any injury or other trau
once. 1150 Cleveland Street, Baltimore, Maryland 21230 Mary Carnes/ Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 23. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Lac. Celle 299 Frederick Road, maltimore, Maryland 21220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Peritonitis 12 Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sheek Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed Reipirate and burial-tran Due to (or as a consequence of). Box 68760 physician Physician/Medical ΜI the as attending p IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown director, page 2 should Completed Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has b stely filled in by the funeral director, page 2 st 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 **N**0 2 🗀 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🚉 🕏 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hou₁∟ the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title ofcertifie 30. Name and dress of person who completed eause of death (Item 23a) (Type, Print) Anthony Martinez 906

DHMH 17 Rev 1/2001

State Registrar 31. Date filed Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Karen K. Chai February 2010 pM 4:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country)
Taiwan Days Hours 09/23/1937 Director 045-60-2958 Yrs 72 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Ellicott City 1 Yes 2 X No Howard 10e. Street and Number ò 10g. Citizen of What Country? Examiner must be 23a Funeral 3029 Seneca Chief Trail 21042 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ò ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Asian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. fant: If item 27 is marked other than jury or other traumatic event, the I 4 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ൧ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy F. Chai - daughter 3029 Seneca Chief Trail Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If its
any injury or of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Grdns: 02/27/2010|Marriottsville, MD Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 13 months Physician/ Brain Tumor disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or impury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 R No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗌 No Yes 2 No 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: ျပ 1 Inpatient 2 I ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury ■ Natural Vithin 24 hours and To the Funeral Director. After To the Funeral Director. 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 156531 Feb. 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Dr. Harry Li

31. Date filed (Month, Day, Year,

FEB 25 2010

Suite 301

Columbia, MD 21045

8600 Snowden River Parkway

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February PM WILLIAM CAPORELLIE С. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death P tor(Sex 1 X M 2 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** If Under 4 Hrs. 9. Birthplace (State or Foreign Months Hours Min. Month Day 4/18/3 174-26-4936 PHILA Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c, City, Town or Location Director 10d. Inside City Limits PA DELAWARE DARBY TWP. 1 🗆 Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 100 WESTBRIDGE RD. 19036 u.s. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" 3 Nidowed 4 □ Divorced If Yes, Give Year or Dates Specify: WHITE If item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 PRINTER UNION Be 17. Father's Name (First, Middle, Last)
WILLIAM CAPORELLIE 18. Mother's Name (First, Middle, Maiden Surname ELTZABETH SEC ဂ္ဂ SEGER permit. Page 1 and 2 should be Department of Health and Mer Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM A. CAPORELLIE 100 WESTBRIDGE RD. GLENOLDEN, PA. 19036 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) DELAWARE COUNTY CREMATORY 2/13/10LANSDOWNE, PA. Signature of Funeral Servic, Lice see 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 23a Part 1. Enter the disease, or co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. emonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any sading to a made cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available 24a. Was an this certificate has autopsv prior to completion of cause of death? 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? ြု 1 🗌 Yes 2 1 No Other: 1 Inpatient 2 I 4 Nursing Home ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) . Manny of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. injury at After 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death e Funeral Director: A pleted filled in by the fo Accident Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) [1] 10 and add ess of person who completed cause of death (Item 23a) (Type, Print IONIS 31. Date filed (/ onth, Day, Year, State Registrar DHMH 17 Rev 7/2009

porelle,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05404 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lucila V. Cardenas Month p^{M} 2010 Medical February 5:10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casev House Rockville Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day June 15 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X** F Days Hours ^{Year} 19<u>24</u> Months Country) Director 85 Yrs 212-64-8942 Peru Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits or 28a-f sh notified a MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number b 10f. Zip Code 10a, Citizen of What Country? must be 23a Funeral 6530 Democracy Blvd. 20817 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【※No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes Give 1 X Yes 2 □ No Specify: Peruvian White "natural" 3 Widowed 4 Divorced Specify Year or Dates item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Clerk Retail Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maria Zevallos Cardenas Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1901 Hickory Hill Lane, Silver Spring, MD 20906 Antonio W. Yaran / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ₹ <u>₹</u> 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or Final Journey Crem. 2/22/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD Signature of Funeral Gervice Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year the 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advanced Dementia, Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Chronic Obstructive Pulmonary Disease Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy death? certificate 2X□ No 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital ဥ 1 🗌 Yes 2 X No Other: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) Hospice 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural (Month, Day, Year) 5 Pending n 24 hours after death.

e Funeral Director: A
bleted filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Sulcide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 ho

To the Fune

completed f (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diana Ruckert, CRNP, 6001 Muncaster Mill Road, Rockville, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 25 PM **Physician** February Jarlene ameror ZULU /Medical 4c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Seasons Hospice Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex Days **Funeral** Months 1□M 2ØF 9-22-1958 220-74-2414 51 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23s or 28s-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the M-dical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Pikesville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 7406 Sudbrook Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Baltimore, Maryland 21215-0036 Specify: African-American Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Baltimore county 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gordon Dillard Shirley Montague ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7406 Sudbrook road, Pikesville,MD 21208 Clifford R. Dameron/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of I
Important: If ite
any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Veterans 3-4-2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wille Funeral Pine P.A of Politimore Co. Sign sture of Funeral Service Licenses 9200 LibertyRoad, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a or sequence of): **Physician** /Medical Examiner estrictive Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) ed by the a ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed the should be detailed Division or Vital Records, þ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Kidney disease Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Mellitu 24a. Was an autopsy performed? Yes 2. No has page 2 this certificate 1∐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Be 4 Nursing Home 5 Residence 6 Dother (Specify) Vic Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28c. Injury at Work? completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: After or Attending 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sidnatule 00053337 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seay Q m. th Ave rue 35 203 28

State Registrar 31. Date filed (Month, Qay, Year)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 05405 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** February aw son 2010 20 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ilstown easons 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Security Number (In yrs. last birthday) If Under 24 Hrs. Hours Min. Funeral 251-18-0053 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c_City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Completed by Funeral Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21207 USA 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1⊡Yes 2**50**∜lo Baltimore, Maryland 21215-0036 Specify. Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Mich. e. Maiden Surname. Be orie Drowr INSON ٥ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) GwynnOak Northland MD 2120+ Kenae Jones 20b. Place of Disposition cemetery, cremator Date 20c. Location -20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State Baltimore, MD -1-10 oudon 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licenstee Variand Address of Ecility Greene Fun Vaugh C. Press. SISITS alts. Nat'l Pile.

23a. Partl. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage **Physician** Renal disease END disease or condition resulting in death) /Medical Due to (or as a conse v ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by a page 2 should be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an remente was ... autopsy performed? Ves 22 No death? 1 ☐ Yes 2 □ No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar

31. Date filled (Month, Day, Year) FEB 25 2010

29b. Signature and title of pertities

one)

Smith Avenue Suite 203 2835 (NID 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D005333 7

29d. Date signed (Month, Day, Year)

Baltone, Md 21209

20 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 9:46 AM M February <u> Iosephine W. Dallam</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 1721 S. Fountain Green Road Bel Air If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth **Funeral** 1 - M 2 - F Months Days Hours Min. (Month, Day, une 13 Year) Country) Maryland Director June 213-38-6832 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10c. City. Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No MD Harford Bel Air 10f, Zip Code 5 10e Street and Number 10g. Citizen of What Country? items 23a Funeral 21015 USA 1721 S. Fountain Green Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 5 à 1 Never Married 2 Married white 1 ☐ Yes 2X No Specify: Maryland 21215-0036 If Yes, Give Year or Dates Specify: "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) retail salesperson 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harriet Susannah Webster should be William Dallam III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1912 S. Fountain Green Road Bel Air, MD 21015 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 she Department of Health an Important: If item 27 is Margaret K. Dallam/niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Signature 1 Europa Serve 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ oronar Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated soorts. Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s autopsy page performe after death.

Director: After this certificate I
in by the funeral director, page 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Dav. Year)

State Registrar

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0. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** LOUISE DEMPSEY /Medical FEBRUARY 17,2010 8:45 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MANOR CARE-ROSSVILLE ROSEDALE BALTIMORE 8. Date of Birth (Month, Day, Year) DEC. 27,1927 5. Social Security Number if Under 1 Year | If Under 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Months Days Hours 82 DEC. Director 217-22-6633 UNKNOWN Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If lien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumating and any injury or other 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2□No MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 RIDGE RD 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify WHITE 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 PHONE OPERATOR AT&T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE DUNN ROSINA UNKNOWN ည 19a. Informant's Name/Relationship (Type. Print) UARDIAN OF 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. MICHAEL HOLLOWAY-PROPERTY 10 N. CALVERT ST. SUITE 200 BALTIMORE, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) OAKLAWN CEMETERY 2/26/2010 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD Part the file disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each line. 23a Part 1 Immediate Cause (Final disease or condition resulting in death) STAGE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. 1 Yes 2 No 3 Probably 4 Vonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate l perform 2 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred s after decral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital 6 24 hours a To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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FEB 25 2010 January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 22, 2010 February 11:22 AM Charles F. Ferrara /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 10054 Carrigan Drive Ellicott City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 08/15/1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2□ F Months Days Hours Min Mary Land 212-26-3116 92 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm "had cal Event ar must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10054 Carrigan Drive 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: 1936–44 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) filed within Hygiene. Social Security Specialist Federal Government 12 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Ferrara Rose Pusateri ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mary Ferrara - Wife 10054 Carrigan Drive Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest MD Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/08/2010 Reisterstown, Maryland 4 Donation 5 Dother (Specify) Veterans Cemeters 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 21. Signature of Funeral Service Licen 5311 Edmondson Avenue Baltimore, Maryland 21229 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one eduse on each line. Immediate Cause (Final **Physician** MRNEW disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably - ☐ Unknown þ nas e 2 s certificate ha this After th funeral within 24 hours after uc.... To the Funeral Director. Af ofter death.

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, the Hospital or Attending Physician:

72 hours after

within /

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Complet				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
e e	25. Was case referred to medical		26. Place of Death	(Check only one)	
0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5X Residence 6	Other (Specify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at	8d. Describe how injury	cocurred
Certificati	3 Suicide 6 Could not be 4 Homicide determined		et, factory, office 2	8f. Location (Street and City or Town, State)	d Number or Rural Route Number,
cal		hysician: To the best of my knowledge, death ominer: On the basis of examination and/or inve			

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

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re and title of certifie

29b. Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Vivian George Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timore 8. Date of Birth (Month, Day, Year) Feb 2, 1935 Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral unk Min. Months Hours Country) Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 √ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3700 Greenspring Avenue #806 21215 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk | 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital 2401 W. Belvedere Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) in state 21. Sign of Funeral Strvice Licensee Runald S. Wave State Anatomy Board 655 W. Baltimore Street Director Raltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnar 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mo Month Pregnant at time of death been signed by the should be detached Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe has page 2 death? certificate Division of Vital 25. Was case referred to medical ector, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral (Month, Day, Year) 5 Pending injury work? Natural 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of e 29c. License number 29d. Date signed (Month, 2010 and address of person who completed cause of death (Item 23a) (Type, Prin 30. Name 82. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** SHELDON GLUSHAKOW 204 MICHAEL 2010 22 F EB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia HOWARD Hospitel County General Howsen If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 X M 2 □ F 219-40-4273 66 Yrs. 05/25/1943 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show id 2 should be filed within 72 hours after death with the Maryla lith and Mental Hygjene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination and the natified at 1 ☐ Yes 2 No Director MD HOWARD ELLICOTT CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2910 MONTCLAIR DRIVE 21043 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **ATTORNEY** LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If Item 27 Is marked any injury or other traumatte ev HERBERT **GLUSHAKOW** FRANCES ပ POLSKY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIE GLUSHAKOW / WIFE 2910 MONTCLAIR DRIVE, ELLICOTT CITY, MD 21043 20b. Place of Disposition (Name of ANSHER) EMUNAH (1997) CHAIN (1997) ANSHER (1997) CHAIN (1997) ANSHER (1997) CHAIN (1997) CHAIN (1997) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/24/2010 BALTIMORE, MD 21. Si bf Funeral Service Dicensed 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ventricular nortalized .disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HyperKalenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of, or Attending Physician: The law requires that the death certificate be executed trar Due to (or as a consequence of) ettending physician for use as the burial Box 68760, Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) Ö the 9 Unknown 9 Unknown signed by t ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has certificate 1 □Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA ours efter death. neral Director: After this filled in by the funeral di Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and tipe of certify 29c. License number 5037 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar MILLIAFL

31. Date filed (Month, Day, Year)

GM

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755 CEDAR LANE Columbin,

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~ .	Medic	al	Anna Maria He 4a. Facility Name (if not institution,			4b. City, Town, or	r Location of	02/22/		nty of Deat	5:55 P M
	Examin	er	Fairfield Nurs		Center	Crowns			1	ndel	
	Funeral		5. Social Security Number		je (In yrs. last birthday)		If Under 2	24 Hrs. 8, Date of Bi	th 2/9/193	9. Birl	thplace (State or Foreign
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	and show lat	o	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
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	th the	al D	10e. Street and Number			10f. Zip Code	c 4		10g. Citizen o		untry?
	ath wil	Funeral Director	1202 Cathedra	L Drive	Ever in ILS 13	Was Decedent of H		in? (Specify Yes or No	USA 14 B		rican Indian,
9	or ite		1 ☐ Never Married 2 🗓 Marr	Armed Forces?	No			in? (Specify Yes or No , Puerto Rican, etc.)	-	lack, White	e, etc.
003	urs afi tural", al Exa	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2X ☐ No			Speci	ify:	White
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21215-0036	led within 72 hours after death with the Maryland Hygene. Other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4 or	5+) I	ne maker			Own Ho	ome	
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Baltimore,	permit. Page 1 a Department of I Important: If its any injury or ot once.		21. Signature of Funeral School L	i nsee		22, Name and Addre		/ Ardent Ci Drive, Ste	emation	n Ser	vices
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09/89	certific nding use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	Π			23d.	Date of de	livery
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Sec.	sician: The law certificate has the irector, page 2 s	omb						per	opsy formed?	death?	completion of cause of
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n 0	ding P th. After funer	Certificate:	1 Natural 5 Pendir 2 Accident Investig	g (Month, Da		worl	yat k? Yes 2□	I	how injury occi	urrea	
Division	Atten er dear ector: by the	artifi	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In	jury - At home, farm, s tc. (Specify)	treet, factory, office		28f. Location City or To	8f. Location (Street and Number or Rural Route Number,		
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			→ 7 1 1 1	MD		D38	958		2/23	120	010
	0/		30. Name and address of parson	who completed cause of	death (Item 23a) (Type	Print)		exa 100	2		aD 21061
	Sta	te	31. Date filed (Month, Day, Year)		MD 208 (ar's Signature	Jun 1719	way	300 00	DUY	ur r	4001001
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Daron Howard		S I- For State	tate of Maryla	and / Depa		Health and			20 l	0 05414	
Physicia		Registrar 1. Decedent's Name (First, Midd	dle,Last)					2. Date of Dea	th	3. Time of Death	
Medical Examin		Daron Damic				4b. City, Town, or L	cention of Door	Month February	16, 2010 4c. County of De	0136 hrs	
		4a. Facility Name (if not instituti Sinai Hospital	on, give street and no	umber)		Baltimore	ocation of Dea	UI.	N/A	501	
Funeral Director		5. Social Security Number 215-25-2852	6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24Hi Hours Mi	n. Oct.	th(MM/DD/YYYY) 9. 11,1988Ma	Birthplace (State or Foreign Country) aryland	
>.	_ h	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locati	00				10d. Inside City Limits	
land f show any once.		Maryland N/			Baltim	ore			1 X Yes 2 No		
n the Maryland 3a or 28a-f show otified at once.	Dire	10e. Street and Number 896 W. Lomba	rd Stree	t		10f. Zip Code 2120		10g. Citizen of What Country?			
	by Funeral	11. Marital Status 1 Never Married 2 N 3 Widowed 4 Di		2🗶 No	1	s Decedent of Hisp es, specify Cuban, Yes 2X No	Mexican, Puerl	o Rican, etc.)	14. Race - American Indian, Black, White, etc. Black Specify:		
hours natur Exam	g	15. Decedent's Education (Spe Elementary/Secondary (0-12)		de completed) 1-4 or 5+)		t's Usual Occupation ost of working life.			16b. Kind of Busines		
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21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	17. Father's Name (First, Middle Robert Howar	rd.				Sta	cey Jac			
MD 21 nd 2 should alth and Me or 27 is ma raumatic ev]٤	19a. Informant's Name/Relation Stacey Jacks	ship (Type, Print) Son/Mothe	er	19b. Mailing 896 V	Address (Street V. Lomba	and Number of ard St	Rural Route Nur reet Ba	mber, City or Town, St.	MD ^{ip} 24 201	
ore, I s I and of Healt If item		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal f	rom State	crematory or oth	ition (Name of cem ner place)	- 1	Date /1/10	20c. Location - City	or Town, State e, Maryland	
Baltimore, permit. Pages I ar Department of Her Important: If ite Injury or other tr	ļ	4 Donation 5 Other S 21. Sign e of Funeral Service	Specify:	Gre		nt Cemet	-1				
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60, ate be e	Medi	IF FEMALE:		outcome of preg	nancy				23d. Date of deliv	ery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ur	1 _ 5	nant at time of de	oth -	tal death 3 her (Specify)	Ectopic pregr	nancy	Month	Day Year	
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On O' ending ath or: Afte	ţi ii	1 Natural 5 Per	nding FOUNT	h, Day,Year) D:	FOUND: 0115 hrs		es 2 🗸 No	Subject sho			
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Tot with Tot com	Medical	29b. Signature and title of certif	and manner			29c. License		2	29d. Date signed (/		
		Mica		My		O.C.N	1.E.		February 17, 2	010	
		30. Namé and address of perso Russell Alexander M		ise of death (Item Medical Exan		Penn Street,	Baltimore, N	MD 21201			
Sta Regist	ate	31. Date filed (Month, Day, Year	2010 Z.R	egistrar's Signa	ure hark						

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	Funeral Director		5. Social Security N			Age (In yrs. I	ast birth	day) If Under		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Aug 27	rth	9. Birt	nplace (State or	Foreign
1		'n	Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit		or Location			iring so 7	1 / -		10d. Inside Cit	y Limits
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Director	Maryland		imire	E	lge.	mere						1 🗆 Yes	2 No
	with the s 23a or ust be r	Funeral D	28/7 S		us Point	Rock	d	10f. Zip C	219			10g. C	itizen of What Co	fes	
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400	72 hours after n "natural", or fedical Exami	eted k	3 🗆 Widowed		If Yes, Give Year or Dates		160 [1 Tes 21	<u>, , </u>			16b	Specify: Bl	ack	
34 1215	within 72 h giene. ier than "na it, the Medic	Completed	(Spec	ecify only highest	college (1-4 o	r 5+)	1	Give kind of work of ife. DO NOT use re	done du	ring most of work	king		J. Lange		
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33 / lcBaltimore,	Page 1 ment of I ant: If its ury or of		1 🕍 Burial 2	•	B ☐ Removal from Sta	ite // c	cemetery	crematory or other	er place,		Date	Ι.	cwinson lla		
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16 Box	e death the atte	Physician/Medical	in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	☐ No	1 □ Live Birt 4 □ Pregnan 9 □ Unknow	t at time of		3 Ectopic pre 5 Other (spec					Month	Day Y	'ear
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H0LRecords,	> 0101	Completed									24a. Was auto peri 1 \subseteq Yes	yago	prior to	copsy findings a	vailable ause of
≥ tal B	To the Hospital or Attending Physician: The law I within 24 hours after cleath. To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s	Be	25. Was case referr examiner?	/	Hospital:					ce of Death (Chec		2 12 1	No 1 □ Yes	2 No	
of Vi	ng Physi ter this o neral dire	te: To	1 ☐ Yes 2 2 27. Manner of Deat		1 Inp		28b. Ti	patient 3 DOA me of jury 280	Other c. Injury a work?	4	ome 5 Res 28d. Describe		6 Other (Spec ry occurred	ffy)	
GO.	Attendir r death. ctor: Af y the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	5 Pending Investiga 6 Could no determin	ation ot be 28e. Place of I	njury - At ho	ome, fari	M n, street, factory, o	1 🗆 Y	′es 2 □ No	28f. Location	(Street a	nd Number or Ru	al Route Numb	er,
	To the Hospital or Attending Physician: within 24 hours after cleath. To the Funeral Director: After this certific completed filled in by the funeral director.				building, Physician: To the best	etc. (Specify		eath occurred at th	o timo	data and place a	City or To			ted	
	the Hos nin 24 ho the Fun npleted	Medical	(Check 2 only one) 3	2 Medical Ex 3 Certifying N	aminer: On the basis of Nurse Practioner: To t	f examination	n and/or	investigation, in my dge, death occurre	y opinion d at the	, death occurred a time, date and pla	at the time, date	and place the cause	e, and due to the o	cause(s) and mar stated.	nner stated.
4	Vittle Cor		29b. Signature and	title of certifier	10			29c. L	License i	24170		29d. D	eb 23,	2010	
1			30. Name and addr	ress of person w	ho completed cause o	f death (Iten	n 23a) (Ti 0801 (ype, Print)	N.1	Entan	St B	Balt	imore	MD 21	201
Y	Sta Registr		31. Date filed (Moni	th, Day, Year)	32. Reg	ter's Signa	ature	hade	1						
DH	MH 17 Rev 7/2	009		T GU &	U CUIU CO	word.	10.	17							

Soo Wan Hong

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Ctata of Mandand	/ Department of Health and Mental Hygiene
State of Marvianu	Department of Health and Mental Hygiene

UNK UNK	State 1- For State	of Maryland / Depart <i>Certi</i>	tment of Health ar ificate of Death	id Mental Hygier	Neg. No.	201	0 051.10		
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		Mor	e of Death	Year	3. Time of Death		
** dical Examine	500 W1			Feb	ruary 19, 2010	ounty of Death	0600 hrs		
	4a. Facility Name (if not institution, given 7240 Riding Hood Circle	e street and number)	Columbia	Location of Death		ward			
Funeral	Social Security Number 6. S	x 7. Age (In yrs. las			ate of Birth (MM/DD	(YYYY) 9. Bir Foreig	thplace (State or gn South)		
Director	213-29-4/87 1	M 2 F 62	Yrs. Months Da	ys Hours Min.	2/04/4	17 Co	puntry ConEA		
any	Usual Residence of Decedent 10a, State 10b, County	10c. City, T	own or Location /				10d. Inside City Limits		
* .	Mn How.	ARD C	0/2/11/01	14			1 Yes 2 No		
th the Maryland 23s or 28s-f show notified at once.	10e. Street and Number	11/100	10f. Zip Code		10g. Citizer	of What Cou	intry?		
th the last		12. Was Decedent Ever in U.S.	CLE Z/C	ispanic Origin? (Specify Y	es or No- 14	Race - Amer	ican Indian, Black,		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mernal Hygerian and refer to a star of season and surfice of other than "natural", or items 23a or 28a-fishen in other traumatic event, the Medical Examiner must be notified at once To Re Commisted by Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 No	If Yes, specify Cuba	nn, Mexican, Puerto Rican,		White, etc.	- ANI		
s after de ral", or liner mi	3 VVidowed 4 Divorced	If Yes, Give Year or Dates:	1 Yes 2 N			pecify:	On division		
hours	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's Usual Occup- during most of working life	e. DO NOT use retired)		d of Business			
5-0036 ed within 72 hour. lygiene. he.Medical Exam	12		BUSIIV.						
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica Be Comple		. / : / c \ \ /		18. Mother's Name (First,	Middle, Maiden Su	mame)	1-		
2121: ould be fill d Mental B s marked fic event,			19b. Mailing Address (Stre	1	Annual Control	or Town, Stat	e, Zip Code) 21045		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examine. To Re Commileted by	HAK 500 HONG	-BrothER		NG Hood C.	IR, COLU	MAI	MIND		
re, I s l and f Healt If item	20a. Method of Disposition 1 Burial 2 Cremation 3		ace of Disposition (Name of c ematory or other place)		20c. Lo	cation - City or	r Town, State		
Baltimore, bernit. Pages I a Department of He Important: If ite	4 Donation 5 Other Specify	AR	DEN + CROWNA 22. Name and Addre	1-2-1-1	10 HA	NOYE	R, MD		
Balti permit. Departn Import injury	21. Signature of Funeral Service Licer	11/17 4		SISILFOOD	Res 12	Salh.	21 1 2074		
Physician	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	olications that caused the death. I			ratory arrest, shock	, or Needs	Approximate Interval Between Onset and		
/Medical. Examiner	Immediate Cause (Final disease a.	Thermal inju					Death		
	or condition resulting in death)	Due to (or as a consequence of)	:						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of)							
ed nsit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)							
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	<u> </u>	AMENDED-							
30, te be e nysicial		AMENDE 3a, 27, 28a		1 3.3.10 TT	23d.	Date of delive	ry		
6876 secrificate anding physe as the b	past 12 months?	1 Live birth	2 Fetal death	Ectopic pregnancy	N	Ionth	Day Year		
Box e death c the attented for us	1 Yes 2 No 9 Unknow	- L	other (Specify)						
Records, P.O. Box 68766 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the terminal for the cate of the control of the contr	Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying cause	e given in Part I.			the cause of death? bably 4 Unknown		
S, P. quires the signer of signer o					4a. Was an	24b. Were a	utopsy findings available		
cords,					autopsy performed?	death?			
of Vital Records, P.O. ng Physician: The law requires that the there this certificate has been signed by hereal director, page 2 should be detach.			26.Pla	ce of Death (Check only o	Yes 2 No	1 🗸	res 2 No		
is is sign	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursing Hon		ce 6 🗸 Oth	er: Scene		
ling Ph	1 2/ Manner of Death	28a. Date of Injury (Month, Day, Year)	· · · · · ·	Ves 2 X No sul	Describe how injury ject die	d of			
Division tal or Attendi rs after death. al Director: /	Natural 5 Pending 2 Accident Investigal	28e Place of Injury - At ho	Fd 5:59 am me, farm, street, factory, office	Ise	f-immoli ocation (Street_ap	ation J,Number or F	tural Route Number, City		
Divi	1 Natural 5 Pending 2 Accident Investigat 3 X Suicide 6 Could not determine	be		Coi	umbia, M	D Rid	Rural Route Number, City ing Hood Cir		
8 - = 5	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and due on the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed								
To the within To the compl	29b Signature and title of certifier	and manner stated		nse number			Ionth, Day, Year)		
	29b Signature and title of certainer	-	l	C.M.E.	Febr	uary 20, 20	010		
- 1	30. Name and address of person who	completed cause of death (Item							
Ø V	Ling Li, MD Assistant I	Medical Examiner 111	Penn Street, Baltimore	e, MD 21201					
Sta Registr		32. Registrar's Signatu	A base						
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 40 M Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arunde1 Anne Arundel Medical Center Anne Annapolis Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Georgia Months Days (Month, Day, 1 M 2 Hours Min. Director 475-40-7552 73 1936 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2X No Annapolis Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1492 21409 United States Ridout Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married à 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Arts & Crafts Crochet Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Fred Hachtel Marie Carstens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1492 Ridout Lane, Annapolis, Maryland 21409 C. Wesley Haywood/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 24. 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 Baltimore. Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilityCremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be use as the Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? Pregnant at time of death Month Year the should be detached 9 Unknown Unknowr Division of Vital Records, P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law page 2 s this certificate has autopsy performed' death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1- Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending (Month, Day, Year) To the Hospital or Attendir within 24 hours after death. To the Funeral Director; Ai 1 Tes 2 No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier nova 232010 DEFENSE HIGHWAY ANNAPOLI MOLIYOI 31. Date filed (Month, Day, Year) **FEB 25 2010**

State Registrar

32. Registrar's Sj

			Pleas	e Type or Prin						-	_	gible.	
			For State Registrar	State of Ma	arylanc		rtment of tificate of			ental Hy	/giene Reg. No. 2	010	05418
П	Physici		1. Decedent's Name (First, Middle, William H. I	_{Last)} Heavrin						2. Date of De Month	Day	2010	3. Time of Death 7:35p M
May 1	/Medic Examin		4a. Facility Name (If not institution,	\	D a L	1.00.00	4b. City, Town,		of Death	CIT	4c. Coun	nty of Death	
-	Funeral		SINAI HOSP 5. Social Security Number 6	5. Sex 7. Age		timare st birthday)	If Under 1 Year		24 Hrs.	8. Date of Bi	/	9. Birthpl	ace (State or Foreign
	Director		215-22-1661	1 X M 2 □ F	83	Yrs.	Months Days	Hours	Min.	Aug. 2	2, 1926	Mar	ÿland
	yland yland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10	d. Inside City Limits
	Ba-f sl	Director		imore	Со	ckeysv					10.000		1 ☐ Yes 2🏋 No
	3a or 2	al Dir	10e. Street and Number 2 Hillary Way	V			10f. Zip Code	21	1030		10g. Citizen o	USA	ryr
	r death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Forces? If Yes, specify Cuban, Mexican, Puer				rigin? (Spe	ecify Yes or N Rican, etc.)		ace - America lack, White, e	
336	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Exeminer must be rodified at	þ	1 ☐ Never Married 2 ☐ Married 3 🏹 Widowed 4 🗇 Divorced	d 1XIYes 2 □ N If Yes, Give Year or Dates.4	9 '- 52	2 1	□Yes 2XNo	Specify.	:		Spec	е	
2-0	72 hou	eted	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual Occu	durina mos	st of workir	ng		Business/Ind	ustry
21215-0036	within giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-N/A	+)		OONOT use retire	,	cin C	orp.	Heatin Air		tioning
pu	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.	Be	17. Father's Name (First, Middle, La					18. Moth			e, Maiden Surna		
Maryland	should be fi and Mental H s marked ot aumatic ever	ို	Donald Chisho 19a. Informant's Name/Relationship			19b, Mailir	g Address (Stree	et and Numb		herine			Code)
	and 2: ealth a n 27 Is ner trau		Daniel Heavrin	/Son			3 Keeney	Mil1					
nore	ages 1 ent of H t: If Ites / or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		ce	ace of Dispo metery, cren aney	sition (Name of natory or other pla lalley	ace)	Feb.			n - City or To	
altimore,	permit. P Departme Importan any injur		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Function Living Li		Mem	22	Gardens Name and Addr emmon Fu	ress of Facili	201			ium, M	
8	9 9 E 8 9		23a. Past 1. Enter the disease, or	Michael J.		e 10	W. Pad	onia I	Road	Timoni	um, MD	21093	Approximate
	Physician [®]		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each lin	ie.		Hear	TN		c ==	A- All		Interval Between Onset and Death
Ų	/Medical Examiner		resulting in death)	Due to (or as					1	11	(EN	MIRES	
		ě	Sequentially list conditions,	b. Due to (or as a	a eunesqui	onice of j.			1/	1 pear	D BY MENTEN EN		
8	executed an and nal-transit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	2 000000011	ence of):			Mi	CATION APPRO			
68760,	te be ex ysician ie buria			d	a consequi	erioc oi).			G.M.				
x 68	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicia rial director, page 2 should be detached for use as the burn	Physician/Medical	IF FEMALE:	23c. If ves, outcome	of prognan	201/	_						
Box	death of attention of for us	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 🗀 Fetal	death 3	Ectopic pregnar Other (specify)	ncy				Date of delive Month	Day Year
P.O.	that the dended by the detached		9 Unknown Part II. Other significant condition	9 ☐ Unknown	ut not resul	ting in the u	nderlying cause g	iven in Part	1.	23e. Did	tobacco use co	ontribute to th	e cause of death?
rds,	quires that an signed uld be det	d by	Hypertension	١						1	Yes 2 □ No	3 ☐ Prob	ably 4 Unknown
leco	e law requir has been s le 2 should	Completed	Hip Fractu	RE						24a. Wa aut	opsy	prior to cor	osy findings available inpletion of cause of
tal F	sician: The certificate rector, pag		25. Was case referred to medical					26 Plac	e of Death	1 ☐ Yes		death? 1 ∐ Yes	2 No
of Vital Records,	hysicia this cer al direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie			I 3 LI DOA	ther: 4□N			sidence 6 □C	Other (Specif))
ouo	ding P th. After i	tion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Day		28b. Time of Injury Un(CA & W		uryat ork? ⊒Yes 2.⊻		28d. Describe	how injury occ After		of balance
Division	I or Attendi after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 280 Place of Inju	ury - At hor	ne, farm, str	eet, factory, office			City or To	(Street and Nui	mber or Rura	Route Number,
Ω	ospital o			HomE Physician: To the best							e cause(s) and	manner as s	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	one)	xaminer: On the basis of and manner sta		ion and/or in			eath occurr	ed at the time			
	To COO	2	29b. Signature and title of celtrifier	M				054	22 X	-	Felor Un		1 2010
	10		- 0	ho completed cause of d	eath (Item	23a) (Type,	Print)	+	TA		f BA	-	
	Sta	te	FCEDERICL 31. Date filed (Month, Day, Year)	BURIG JR,			VAI	(105)	JI CA	(0)	TSA	ITM	1014

Registrar DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** telda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A umn If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 □ F Director 214-50-3435 Sep 16, 1946 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, it a Medical Example or must be rectified at 1 Yes 2 No Director Maryland N/A **Baltimore** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 827 Chauncey Avenue 21217 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No \$ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any injury or other traumatic event, trailly any once. Elementary/Secondary (0-12) College (1-4or 5+) L.S.G. Sky Chefs Food Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Gilyard Virginia Gaskins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Steven Harrod 827 Chauncey Avenue Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) 03/02/10 Windsor Mill, Md. King Memorial Park uneral Serv 22. Name and Address of Facility 21. Signature of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** reprat Hemerryagn /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes ≠2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours an 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ည 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2HRISTOPHER 5 Greene St Baltimore 22 31. Date filed (Month, Day, Year) Registrar's Signature. State FEB 25 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HAMILL Day Month Physician Year 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONE BALTIMORE CENTER MO CROMWELL (0) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 18,1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F 216-24-4032 82 MD Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director MD BALTIMORE LUTHERVILLE filed within 72 hours after death with the Hygiene. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 410 ROCKFLEET RD #204 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📜 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE <u>ک</u> 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 A/C & REFRIGERATION SECRETARY 7 is marked other traumatic event, the permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked other any lijury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERTHA HAYNE HUGH HAMILL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1830 JORDAN SAW MILL RD PARKTON, MD 21120 MELANIE LONG-GUARDIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 2/25/10 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licensee 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part | Enter the disease shock, or heart failure Approximate Interval Between Onset and Death , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Let only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2417 /Medical Due to (or as a consequence of) Examiner Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed ANONEXI burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page 2 nned 2∐No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1-Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Director; / investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

Division or Vital Records,

Baltimore, Maryland 21215-0036

Box 68760.

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State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

elvo do My

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8710 EMBE NO

29c. License number

02/27/3010 D32717

29d. Date signed (Month, Day, Year)

BATIMONE MES 21234

Division of Vital Records, within 24 hours a To the Funeral L

Baltimore, Maryland 21215-0036

Box 68760;

P.O.

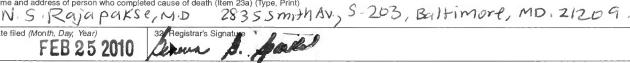
State Registrar

31. Date filed (Month, Day, Year) FEB 25 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MSRajapawseMD



29c. License number

DO057465

29d. Date signed (Month, Day, Year)

2/17/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $20\overset{\text{Year}}{10}$ Thomas Patrick Johnson М Feb 2308 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carroll Carroll Hospice-Dove House Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** XX M 2 D F Yrs Director 213-32-3294 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2658 Bird View Rd 21157 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with n and Mental Hygien 7 is marked other th Antique Dealer Self-Employed permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen C. Hanson William H. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Jenkins/Daughter 502 Hill St., Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 🗌 Dø ation 5 Other (Specify) Carroll Crematory 2/19/2010 Winfield, MD 21. Signar Funeral Service Life ²²Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 er the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pa 1. E ock, or eart failure. List only one cause Opset and Death Imm iate C use (Final disease or condition Physician Medical ulting in geath) consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Disease of finjury to the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death cate has been signed by the page 2 should be detached 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown cant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other 23e, Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury Natural 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nume Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c

State Registrar 30. Name and address of p

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28th of Maryland Department 201 Health, and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ February Gisella M.D. Johns 2010 10:57 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Hungary Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Oct. 19, Days 1 M 2 X F Hours 78 1931 Director 044-38-2521 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director items 23a or 28a-f s ner must be notified 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9509 Edgeley Road 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene.
ed other than "
event, the Mec College (1-4 or 5+) Elementary/Seconday (0-12) Sales Associate Jewelry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even onee. Ith and Mental H Joseph Dudas Maria Vargas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David G. Johns/Husband 9509 Edgeley Road, Bethesda, Maryland 20814 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cemetery, crematory
Montgomery
Crematorium, February 4 ☐ Donation 5 ☐ Other (Specify) Inc. 17, 2010 Bethesda, Maryland 21. Signatura of Funeral Service Licensee

Houow N. Chou Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 36 Hours Immediate Cause (Final Physician/ Subarachnoid Hemmorrhage and Subdural Hematoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner oms Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and led by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be Chronic Anticoagulation Therapy Be Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 🗌 Yes 2 🔲 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 유 1 X Yes 2 🗌 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural X Accident 5 Pending 17 10 UnknownM 1 ☐ Yes 2 🔀 No Investigation Fell Down Stairs completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office Place of Injury - Action building, etc. (Specify) Home 28f. Location (Street and Number of Bural Route Number, City or Town, State) 9509 Edgeley Road Bethesda, Maryland determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death

Allen A. Nimetz, M.D

FEB 25 2010

31. Date filed (Month, Day, Year)

10:57 PM

(Item 23a) (Type, Print)

D07147

55%0 Wisconsin Avenue #700, Chevy Chase, Maryland 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 2010 Рм 3 30 OMARE KING Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Ye . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 230-19-3301 30 7979 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director FREDERICK FREDERICK MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral SA PLACE 21701 1001 RIVERWALR Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Never Married 2 Married ş 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify: Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. To is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) UNEMPLOYED GED Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev KING THOMAS WELDON SHELLA A. HARRIS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (515TOR) 21701 PATEL RIVERWALK PL. FREDERICE KELU 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State FOB 22, 2014 SMITHSBURG MD. SMITHSBURG CROM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6A RY L. ROLLINS FUN. HOME my d. Kolley SOUTH ST FREDERICK MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or height failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIRCHOSIS Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-trans Cause (Disease or linjury that initiated events been signed by the attending physician and should be detached for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) ☐ Yes ∠ ∟ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has perform Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2× No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in magnitude death occurred. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signatur

le of certifier

Praveen K Bolarym

31. Date filed (Month, Day, Year) FEB 25 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signa

Registrar

DOOG 2213

Frederick, mo

#225

196 Thomas Johnson DR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #26 Per Verb G900 2/25/2010 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Ye ar **Physician** 4:20 Рм Thomas A Koteles Feb 23 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Montgomery County General 01ney Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 5/28/1941 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** Days 1⊠M 2□F Months Hours Min 273-38-9165 68 OH Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 1 ☐ Yes 2XXNo Director MD Howard Mount Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21771 2484 Florence Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) Yes Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 Never Married 2 Married White 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ground Maintenance Brookgrove Foundation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephan A. Koteles Magdalene Tomor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2484 Florence Rd. Mt. Airy, MD 21771 Jerrilynn Koteles Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Carroll Crematory 2/25/2010 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory 1212 W. Old Liberty Rd. Winfield, MD 21784 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physiclan** MINUTES disease or condition resulting in death) /Medical Due to (or as a consoluence of) SCLEROTIC CORDNARY ARTER Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform this certificate 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Mo Other: 4 Nursing Home 5 Residence ည 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident I Director: d in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number arge and address of person who completed cause of death (Item 23a) (Type, Print) 15/61

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician 232010 ebryary 0 /Medical 4c County of Death 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Hospita Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs (In yrs. last birthday) **Funeral** 213-80-4288 Days Months Hours 1**∑**M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Expressions to ust by notified at 1√Yes 2 No Baltimore Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA tvenue tanward Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Rimble Javid Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT (se retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. abover is marked other 18. Mother's Name (First, Middle, Maiden Surname er's Name (First, Middle, Last, Be Pages 1 and 2 should be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev erna ပ or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number 19a. Informant's Name/Relationship Balto. ernal 20c. Location - City or Town, State 20b. Place of Disposition (Name of gemetery, crematory or other place, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, and 27-10 4 ☐ Donation 5 ☐ Other (Specify) ne Fyneral Services 21. Signatur of Funeral Service Licensee 1 Balto. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ادد meumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) ☐Yes 2☐No P.0. been signed by the should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2☐ ER/Outpatient 3☐ DOA 1 ☐ Yes 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of co who completed cause of death (Item 23a) (Type, Print) Caton Ave, Baltimore, 900 Mason 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 25 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day February 23, **Physician** 2010 4:30 pM Ruth Lutzi /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Gaithersburg Wilson Healthcare Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours 1 ☐ M 2 🕱 F 10. Germany 86 Apr. Director 578-48-7903 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Examinar is ust be notified at 1 ☐ Yes 2 XNo Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number should be filed within 72 hours after death with 20879 United States 5 Flower Hill Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 X Never Married 2 Married White 1 ☐ Yes 2 X No Specify. Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Beauty Salon Beautician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (h and Mental F Unknown Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Flower Hill Court Gaithersburg, Maryland 20879 Pages 1 and 2 Health a Finnelle, Daughter 20c. Location - City or Town, State If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. þ 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Department o Important: If any injury or Baltimore, Maryland Metro Crematory, Inc. 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licenses Elice Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or a consequence (f) Examiner law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 No 2 □ No certificate 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1∐Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: After t 1 Natural 5 Pending investigation n 24 hours after death. e Funeral Director; Aft etely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 1/2001

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Maryland 21215-0036

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Records,

Division of Vital

31. Date filed (Month, Day, Year) **FEB 25 2010**

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Type, Print) ROBERT SIRSCHBACH

Medical

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

201 RUSSELL AN GAITHERSOURG, A

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Feb 201<u>0</u> 4:30 PM Gilberte M. Langlois Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Ellicott City Morningside Assisted Living 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Social Security Number 8. Date of Birth Hours 047-18-8914 1 M 2 StF 10/31/1918 Director MF. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Woodbine Carroll 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21797 USA 7226 Morgan Rd items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Examiner or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 XWidowed 4 ☐ Divorced White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theophile Soucy Olive Dumond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7226 Morgan Rd., Woodbine, MD 21797 Ronald D. Langlois / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Ardent Cremation 2/24/2010 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Funeral Service Licensee M01044 allini 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Lo Vas Cular Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Other: ျ 1 Tes 2 🖳 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ②COther (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, usair occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

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29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

FEB 25 2010

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32. Registrar's Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 109

3064

Back River Meck Road

chruay 24 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lester Lyt1e 02 2010 03:50P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8090 East Phirne Road Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Funeral Min. 1 XX M 2 D F Director 205-03-1985 95 02-28-1914 Pennsylvania Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8090 East Phirne Road 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Manufacturing Supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mabelle Yost Clarence Lytle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Beverly Lytle / Daughter 21061 8090 East Phirne Road Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March l. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Elkridge, MD 2010 Meadowridge Mem. Park 22. Name and Address of Facility 21. Signature of Funeral Service Licens 1 2nd Avenue SW Glen Burnie, MD MO1580 & Cremation Services. Singleton Funeral 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 1ears Medical resulting in death) Due to (or as a consequence of) Examiner menta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami potral or Attending Physician: The law requires that the death certificate be executed ours after death.
eral Director: After this certificate has been signed by the attending physician and filled in by the Inneral director, page 2 should be detached for use as the burial-transit filled in by the Inneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 U 9 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 X No Other: 1 🗌 Yes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending X Natural 1 🗌 Yes 2 🗆 No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7900 Oak Point Amy Schuler 31. Date (Jed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

FEB 25 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ FEBRUARY 2010 8:20 A M ARNOLD F LAVENSTEIN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY CHEVY CHASE 8100 CONNECTICUT AVE., Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Hours 9/28/1916 93 214-44-6959 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No CHEVY CHASE MD MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code Funeral USA 20815 8100 CONNECTICUT AVE., #407 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married WHITE Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h th and Mental Hygiene. 77 is marked other than "n College (1-4 or 5+) 5+ Elementary/Seconday (0-12) PHYSICIAN MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROSE S STEINBERG LAVENSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 shown the shown the short th 8100 CONNECTICUT AVE., #407, CHEVY CHASE, MD 20815 ELEANOR LAVENSTEIN/WIFE Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 200 Place of Pision (Name of cemetary, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 2/24/2010 BALTIMORE, MD CHIZUK AMUNO CEM. 4 Donation 5 Other (Specify) Signature o Funeral Service 22. Name and Address of Facility 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD INC. 21208 23a. Part 1. Enter the disease, or complications that caused the ceat shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Beath 1 a Hera tmyotrophic Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day 2 No 9 Unknown Division of Vital Records, P.O. þ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ speti pidemia 2 Probably 4 Unknown 1 Yes Completed To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sis completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of Myocardial interction 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 5 \square Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nd title of certifier License number 29d. Date signed (Month, Day, Year) 29b. Signature 70 Chen, chase MD 20813 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Me Kanara ms 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

10-01410 **UNK UNK** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day February 16, 2010 1432 hrs Tammy Laverne Madison lical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore N/A8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 214-98-9438 Months Davs Hours 6, 196 Gangia Oct. Director 45 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No Baltimore N/A28a-f shov Maryland death with the Maryland 10f. Zip Code 21 21 5 10e. Street and Number 10g. Citizen of What Country?
USA 5246 Linden Heights Ave 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funera "natural", or items Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married 1 Yes 2 X No Black after If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced ģ or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 hours Completed Personal Touch Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ni jinjury or other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Assistant Nursing Agency 11th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Mack Donald Madison Clara Bell Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print 5246 Linden Heights Avenue Baltimore, MD Clara Madison/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 2/26/10crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn,Maryland Woodlawn Cemetery 4 Donation 5 Other Specify. 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 21. Signature of Funeral Service Licenses 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** /Medical Death a Multiple Injuries Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and d Physician/Medical UNPENDED AMENDED attending physician or use as the burial requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 2 1 Yes 2 V No 3 Probably 4 Unknown σ, Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy The law has performed' death? page ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Vital Hospital or Attending Physician: director Be Other₄ Hospital: 1 / Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 🗸 Yes ō 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27 Manner of Death Feb 16, 2010 Certification: Subject was pushed into the street and then run 1 Natural Division 1 Yes 2 ✓ No 5 Pending Director: d in by the f death. over by a truck 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Greenmount Avenue at 24th Street, Baltimore, MD (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) n O.C.M.E. February 17, 2010 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li. MD 31. Date filed (Month, Day, Year) FEB 25 32 Registrar's Signatu State enerce. Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#TUE, perINF, G901, 3/3/2010, WS

State of Maryland / Department of Health and Mental Hygiene O. I. O.

		1 = For State Registrar	State of Maryland		ificate of		иенан пу	Reg. No.	2010	03432	
Dhysia	ian	Decedent's Name (First, Middle, Last					2. Date of De		Year	3. Time of Death	
Physic /Medi		ELNORA		IN			07	17		5.50 PM	
Exami	ner	4a. Facility Name (If not institution, give			4b City, Town, o Balti	r Location of Death	1		County of Death	1	
		FUTURE CARE NUTL 5. Social Security Number 6. Se			If Under 1 Year	IIIOLE If Under 24 Hrs.	9 Date of Bi			aningo (State or Foreign	
Funeral Director			м 25xF 96		Months Days	Hours Min.	8. Date of Bi (Month, Di Sept.				
yland now		10a. State 10b. County	10c. City, T	Town or Loca	ition					10d. Inside City Limits	
a-fe	ctor	Maryland N/A	Ва	altim	ore			1,∏Yes 2□N			
th with the	Funeral Director	1 923 179 ^{et and Number} 1237 Linworth A	venue Apt. 21	В	10f. Zip Code	1239		10g. Citi: USA		untry?	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or iteme 23a or 28a-f show event, if a Medical Exarthrat must be rediffed at	b	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates:		as Decedent of Horses, specify Cuba	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Black, White	e, etc.	
within 72 ho ene. than "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give kir	nt's Usual Occup nd of work done NOT use retire	during most of work	king	16b. Kii	nd of Business/l	industry	
be filed with that Hygien of other the event, Ille	Be	6th grade 17. Father's Name (First, Middle, Last) Ed Hardy Willia	1425	Dom	estic	18. Mother's Nam	ne (First, Middle		Town, State, Zip Code) 21239 more, Mary.land ation. City or Town, State downe, Mary.land is Funeral Tome imore, MD 21215 Approximate Interval Between Onset and Death ad. Date of delivery Month Day Year e contribute to the cause of death?		
s 1 and 2 should f Health and Men fem 27 ie marke other traumatic	2	19a. Informant's Name/Relationship (T) Patricia Alston	rpe, Print)	1 199 May ing	Address (Street		ral Boute Numb	er, City or	r Town, State, Z	^{Tip Code)} 21239	
Peges 1 annent of Heali ant: if item 2 ary or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	20b. Plac	e of Disposit	ion (Name of	T	Date	20c. Lo	cation - City or 1	Town, State	
permit. Peges Depertment of important: If it eny injury or c		21. Signature of Fungral Service Licens		22. 1	Name and Addre	ss of Facility Ch	atman-				
Physician /Medical Examiner		23a. Part1 Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. In the cause on each line. a. Program. Due to (or as a consequent)	owe	the mode of dyir	ng, such as cardiac	or respiratory a	irrest,		Interval Between	
rtificate be executed ng physicien and es the burial-transit	Aedical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent	ice of):	e con Heart	ncer Disear Fouln	u C				
death cer e attendir ed for use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	□Live birth 2 □ Fetal déath 3 □ Ectopic pregnancy □ Pregnant at time of death 5 □ Other (specify)						•	
sign Bag	þ	Part II. Other significant conditions col	en in Part I.			co use contribute to the cause of death? 2 No 3 Probably 4 Unkno					
The law ate has b paga 2 sl	Completed						24a. Was auto perfo 1 ☐ Yes		death?	topsy findings available completion of cause of	
Physicien: The this cartificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea					
Physic this c	ို	1 1 193 2 40	fospital: 1 ☐ Inpatient 2 ☐ ER		3□ DOA Oth	4 Mursing H			Cother (Spec	ufy)	
ding After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28 28e. Place of Injury - At home	b. Time of Injury		yat k? Yes 2 □No	28d. Describe	how injury	y occurred		
P # # C	Certifi	4 Homicide determined	28f. Location (Street and Number or F City or Town, State)								
To the Hospital or Attent within 24 hours eftar death To the Funerel Director: completely filled in by the	ledicai	one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death o and/or inves	stigation, in my o	pinion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
with To	Ž	250. Date signed							e signed (Month	n, Day, Year)	
Sta	ate	30. Name and address of person who co	AMI MD 82 32. Registrar's Signature	IN.	int)	ch st si	nte 30	8 1	BALTIM	ORE MD 21	
Regist	rar	FEB 25 2010	Person S.	par	4						

10-01204 Timothy McKinney	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	0.0
Timothy Mortilley	1- For State Certificate of Death	33
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	1
Medical Examiner	4a. Facility Name (if not institution, give street and number) Sinai Hospital 4b. City, Town, or Location of Death Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Min.	
Director	Usual Residence of Decedent	
v any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	_
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland hent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		
leath with r items 23 nust be no uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
s after der ral", or i	3 Widowed 4 Divorced If Yes, Give Year VNK 1 Yes 2 No specify: Specify: Specify:	_
72 hours n "natur al Exami	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of business/industry	
5-0036 led within 77 Hygiene. I other than the Medical	12th Grade Unk.	
215-C be filed v ntal Hygi rked oth ent, the I Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
212 hould b nd Meni is marl atic eve		
e, ML and 2 s fealth a fealth a frem 27	20a. Method of Disposition 20b. Place of Disposition (Name) of cemetery, Date 20c. Location - City or Town, State	
MOFC Pages 1 nent of fi ant: If	1 🛮 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other, Specify: WT. ZIM CLIMITATU 2/16/2010 Lans downly MD.	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medic.	21. Signature of Funeral Prince Licensee 22. Name and Address of Facility (1) 11 11 - 11 11 11 11 11 11 11 11 11 11 1	l
Physician	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Int. Between Onset	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. <u>Hypertensive atherocslerotic cardiovascular disease</u> Death Due to (or as a consequence of):	_
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by the attence the for use	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be extended this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial on: To Be Completed by Physician/Medic		
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Records, The law requires are has been signage 2 should be ompleted	autopsy prior to completion of cause performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 N	lo
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IVISION or Attendin after death. Director: A J in by the fu	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No	0.1
Division o pital or Attending ours after death teral Director: Afth filled in by the fune Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, or Town, State)	, City
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Med	29a Certifier	
To To		
	O.C.M.E. February 12, 2010 30. Name and address of person who completed cause of death /tem 23a)	
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 900 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIT ELLICOTI 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Months 1**X** M 2□ F 216-**Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Eventiner must be notified at 1XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 210 1100 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) IMPORT Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) FRIEN POLUM 614 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Bernoval from State Columbia in1V CLUMP BIA MEM 4 □ Donation 5 □ Other (Specify) permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac * respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Once and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4007L heimer /Medical onsequence of): Due to (or as, **Examiner** iabetes 6573 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine COY 6 The law requires that the death certificate be executed oronar sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has director, page 2: autopsy certificate 1 □Yes 2 ☑No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **1** No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 7

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State

29b. Signature and titl

2821

agent

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lill

Oak

29c. License number

29d. Date signed (Month, Day, Year)

21742

02, 23, 20/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 8 per Fh 9901 3/5/10 TT State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 45P CLARA ELIZABETH MITCHELL FEBRUARY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK HOSPITAL FREDERICK MEMORIAL FREDERICK 8. Date of Birth 5/31/1927 9. Birthplace (State or Foreign (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🗹 F Days 216-22-8335 Months Min. Hours **→** 82 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director FREDERICK MD. FREDERICK 1-Yes 2 No 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? Funeral WEST SOUTH 23a 207 USA 21701 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. or 1 Never Married 2 Married þ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give "natural", Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 72 than Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE FAMILY permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other trainmast. DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SR. CSTELLE AUSTIN ROLLINS HZUSMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 MADISON ST APT 40 FRED, MD RULLINS (SISTER) ANN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State MAR. 3,2010 FREDORIUR MD. 4 ☐ Donation 5 ☐ Other (Specify) FAIRVION COM. 22. Name and Address of Facility GARY L. ROLLINS FOU. Itum E 21. Signature of Funeral Service License sun Kock 110 WEST SOUTH ST FREDERICK MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestine Heart Ph sician/ Days disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions day leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Que to (or as a consequence by Exami attending physician and for use as the bunal-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 2 No 9 Unknown Division of Vital Records, P.O. has been signed by ge 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons page within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{\subset}\) Nursing Home 5 \(\text{\subset}\) Residence 6 \(\text{\subset}\) Other (Specify) 2 **N** No မ 1 ▲ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 L Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) D43091 2-13-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Are V . Frederick Zaidi MA 801 TOLL filed (Month, Day, Year) 32. Registrar's Signature State FEB 25 2010 Registrar

			For	State of	Marylan		artment of H		-		0110	05107
			State Registrar			Ce	rtificate of	Death		Reg. No.	UIU	00430
est):	Physicia /Medic		1. Decedent's Name (First, Middle VICTORIA	MUEHLB	ERGER				2. Date of De Month	ARY ^{Day} 2		
	Examin	er	4a. Facility Name (If not institution	_			4b. City, Town, o	r Location of Dea	ath	4c. C	ounty of Dea	
			FRANKLIN 5. Social Security Number		NTER 7. Age (In yrs.	last hirthday	BAI If Under 1 Year	TIMORE If Under 24 Hi	rs 8 Date of Bir	th	9 Bir	TIMORE thplace (State or Foreign
l.	Funeral Director		213-01-0010	1 M 2 X F	9.2	Yrs.	Months Days	Hours Mi		iy, Year) 7 . 1 9	17 1	MARYLAND
	and a		Usual Residence of Decedent						DEC.	,,,,	- 1	
	ylanc now at		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	e Mar a-fs	Director	MD BAL	TIMORE		BA	LTIMORE					1 □ Yes 🌂 ☐ No
	or 28	Sign	10e. Street and Number				10f. Zip Code			Ü	en of What Co	
	ath w	la l	2825 LODG			APT.3		21219	/2 // //		J.S.A.	
	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show at other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed For		.S. 13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.))-	Black, Whit	
336	ar", or	þ	3 Widowed 4 Divorced	If Yes, Giv Year or Da	'e		1 ☐ Yes 2 🛣 No	Specify:		S	Specify: WH	HITE
1215-0036	2 hou latura lcal E	Completed	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	nation	working	16b. Kind	d of Business	
215	thin 7 e. an "n Medi	ad l	(Specify only highe: Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired	d) most of w	rorking			
21	ed wi ygien ier th t, the	ပ္ပြ					SORTER	40.44.1.1.1.1			<u> </u>	RK & SEAL
	be d d	Be	17. Father's Name (First, Middle,						lame (First, Middle		urname)	
<u>\frac{8}{5}</u>	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	P_	STANLEY 19a. Informant's Name/Relations	GAJDZIC	KI	10b Maili	ng Address (Street	MAF			Town State	Zin Codo)
<u>a</u>	d 2 sl th an t7 is r traur		ALBERT MUEHLB		TA.							21237
ā,	is 1 and 2 should of Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition	ERGER/50	20b. I	Place of Disp	osition (Name of matory or other place	i	Date		ation - City or	
آ ا	Pages nent of nt: If It		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State				3/2/10) BAI	TIMOF	RE, MARYLANI
Baltimore, Maryland 21	permit. Pages Department of Important: If II any Injury or once.		21. Signature of Funeral Screen									ME 21224 DRE, MD
	TO 2 % O		23a. Part1. Enter the disease, or	complications that c	aused the deat						TTTMC	Approximate
B			shock, or heart failure. List	only one cause on e	ach line.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec		AGE	DE	MENN	14		
	Examiner				or do d donac	4001100 017.						
	京 李 。	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):						
8.	cuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С								
8760,	ate be executed hysician and the burial-transit		resulting in death) cast	Due to (or as a consec	quence of):						
87	ate the	dical		d								
9 ×	certifi ding se as	/Me	IF FEMALE:	23c. If yes, out	come pf pregn	ancy				23	3d. Date of de	elivery
Box	The law requires that the death certific tte has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 Feta	al death 3	□Ectopic pregnanc □ Other <i>(sp</i> ec <i>ify)</i> _	у		-	Month	Day Year
o.	the d y the sched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	own							
ď.	ires that the de signed by the a be detached f	by Pł	Part II. Other significant condition			-			23e. Did	tobacco us	e contribute	to the cause of death?
ğ	w requires been sig should be		CAD,	ATRI.	AL	FIB	RILLAT	10N	_ 1 🗆	Yes 2	140 3 □ F	Probably 4 ☐ Unknown
Vital Records,	aw re	Completed	PANCY	TOPENI	A				24a. Was		24b. Were a	autopsy findings available completion of cause of
ř		mo;					"		perf 1□ Yes	ormed?	death? 1 ∐ Ye	
Ita	ding Physician: The In. After this certificate hat funeral director, page	Be	25. Was case referred to medica examiner?						Death (Check only	one)		
	hysic this or al dire	으	1 ☐ Yes 2 17 No			ER/Outpatie	III 3 DOA		g Home 5 ☐ Res			ecify)
ū	ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	ig ,	of Injury th, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury	occurred	
SIC	ten eath tor; the	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be	of injuny - At h	ome farm st	M 1	Yes 2 □ No	28f Location	(Stroot and	Mumber or f	Rural Route Number,
Division or	al or A s after of al Direct ed in by	Certification:	4 ☐ Homicide determ	ined buildi	ng, etc. (Speci	ify)	neet, factory, office		City or To	wn, State)	(Variber of)	rarar route vulliber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director,	edical (ng Physician: To the Examiner: On the band mani								
	To th within To th	Me	29b. Signature and title of certifie	r			29c. Licens	se number		29d. Date	signed (Mor	nth, Day, Year)
			I Gim Va	retall 6	MD		D4	000 8	?	2	124	10
_	5			who completed caus	se of death (Ite	m 23a) (Type	, Print)	4 = 6	- 0:		1	4
	J		JIN PARSHA	Ll, 9109		NKUI	1 2001	tre D	R, BAL	TIM	UPE,	MD.
	Sta Registi		31. Date filed (Month, Day, Year) FEB 25 2010	32. R	legistrar's Sign	ature						
DHI	MH 17 Rev 1/2		I PR SO COIL	peneria "	p. 19	are				*-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 1:310 M Month 2 William Carson Norwood Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **N/A** Examiner RESCH hal punare 01-If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Min. Jan 8 1928 Maryland **Director** 82 216-24-8654 Usual Residence of Deceden show 3a or 28a-f shov t be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Reisterstown Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23a **United States** 21136 Examiner must 11 Amv Brent Way items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ō ð 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced 1954 Specify: White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Vice President/ Trust Officer Banking Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H pe 1 Gladys Carlton Wiley George Gartrell Norwood other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 11 Amy Brent Way, Reisterstown, Maryland 21136 Karen B. Norwood/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 23. ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 2010 4 Donation 5 Other (Specify) Baltimore, Maryland Metro Crematory, Inc. Signature of Funeral Service Acensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ traunticular remortes Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Dav 1 Yes 2 L 9 Unknown or Attending Physician: The law requires that the urector: Atter this certificate has been signed by in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown whomas y 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an has autopsy performed? Yes 2 Woo 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 1 Donpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 5 🗆 Pending work? Natural iniury Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital completed filled Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29c. License number 29d. Date signed (Month, Day, Year) February 22, 2010 D0066614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nike

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

DOS SOL

440

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32. Registrar's Signature

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Approximate Interval Between Onset and Death 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 42 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35102 Fchruan 22 2010 on mi 8× Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAVLES STREET Baltimore Mayland 5901 north m.D HUDLY Don 31. Date filed (Month, Day, Year) 32. Registraris Signatifie FEB 25 2010 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

10:50 р.м

10d. Inside City Limits

1 Yes 2 No

10-01202 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Yusef Nazemi State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Medical Examiner** USEF February 9, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11301 Seven Locks Road Montgomery Potomac 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director 125-82-1102 Country) / RAN 1 M 2 F 56 Usual Residence of Decedent 10a. State 10c. City, Town or Location any MONTGOMERY 23a or 28a-f show notified at once. MA BETHESDA timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9713 20817 V5A 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married Yes Specify: PERSIAN t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) ULMPLOYED 12 TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JALAL NAZEM, StD16HtH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOHAMMAD BANIHASHEMI 97/3 MONTAUK AVE BENTOSDA MD 20817 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State FEB 22, 200 FREDERICK MA BUMMIC COM. 4 Donation 5 Other Specify 22. Name and Address of Facility CARY L ROUNS FUN. HOWE 110 WIST SOUTH ST FROORIUM MD 21701 21. Signature of Funeral Service Licensee ney a. 23a. Part I. Ente, the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** /Medical a Hypothermia Complicated by Carbon Monoxide Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the bunal - transi The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, IF FFMALE 23d. Date of deliven 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö 2 σ. Completed Records, has been 24a. Was an autopsy performed? death? this certificate ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No After

or Attending Physician: of Vital Division hours after death within 24 hours a To the Funeral I

Director:

completely

DHMH 17 Rev 1/2001

OCME 2006

Medical

1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of 1 🗸 Yes 2 No Other Nursing Home 5 Residence 6 🗸 Other: Scene 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject exposed to cold and inhaled toxic fumes Natural FOUND Pending 1 Yes 2 ✔ No 1500 hrs Feb 9, 2010 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 11301 Seven Locks Road, Potomac, MD determined (Specify) Parking Lot in a Car 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) February 12, 2010

1530 hrs

10d. Inside City Limits

1 Yes 2 No

Approximate Interval

Between Onset and

Death

Year

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registra s Signa

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month ODULANT CLAIRE 1916 ANNA Feb 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1 □ M 2 🕱 F Director 72 03/12/1937 579-52-3715 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, inc. Medical Expenient must be redified at Director 1 ☐ Yes 2 X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9070 D Town & Country Blvd. Funeral 21043 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or ite 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No è Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Thompson Marie Overbey ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Odulana - husband 9070 D Town & Country Blvd. Ellicott City, MD 21043 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ₩ Burial 2 Cremation 3 Removal from State Columbia Mem. Park 03/02/2010 4 Donation 5 Dother (Specify) Columbia, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee M01044 Gle 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** yocardia /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Diabeter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🗔 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb 2010 1 - D

Registrar

DHMH 17 Rev 1/2001

State

HANOVER,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DESA

7804

ARBOR

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 23, 2010 **Physician** 0445 M Katherine Ignatia O'Neill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Asbury Solomons Island Solomons Island 8. Date of Birth (Month, Day, Year) April 25, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗐 Months Maryland 220-30-3258 95 1914 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Calvert Solomons Island Maryland 1 and 2 should be filed within 72 hours after death with the P Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20688 United States 11100 Solomons Island Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Health Nurse Physical Therapist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen I. O'Neill Mary J. Murphy traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25932 Jones Wharf Road Hollywood, Maryland 20636 Susan B. Dean - Friend ant: If item 2 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or New Cathedral Cemetery 02/27/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Dayid J. Weber Funeral Homes P.A.
5311 Edmondson Avenue Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to ras a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consent ence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Ly Spidlom 1 ☐ Yes Be Completed filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 25. Was case/referred to medical examiner? certificate 1 Yes 2 No 26. Place of Death (Check only one) Hespital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **□**1√0 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02723/2018 Mary Helen Purcell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Center Towson 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 1 □ M 2 🕱 F Months Days Hours Min. 0773071919 263-52-0294 Director 90 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director MD Columbia Howard 10e. Street and Number 10f. Zip Code 23a Funeral 5113 W. Running Brook Road 21044 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the <u>Medical Examiner mu</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Completed by 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Church Ministry PURCELL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Douglas Ethel Lynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James N. Purcell, Jr./Son Page 1 and 2 5113 W. Running Brook Road, Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Cremation Services | 02/23/2010 | permit. 21. Signature & Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Cembrovasalar Accident Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown 4 Pregnant a Pregnant at time of death 5 Other (specify) ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Heat Coronary Diseas Director: After this certificate completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 70 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of M Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one)

RNP

N. Challs.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? Yes Other: 4 Nursing Home 5 Residence 6 (M)Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) Hbruan 23,2010 MD 21204

3. Time of Death

Α

5:19

9. Birthplace (State or Foreign Birtnpic. Country)

10d. Inside City Limits

Interval Between Onset and Death

weeks

1 ¥ Yes 2 □ No

4c. County of Death

10g. Citizen of What Country?

Specify:

Religion

16b. Kind of Business Industry

20c. Location - City or Town, State

Hanover, MD

14. Race - American Indian,

White

Black, White, etc.

USA

Baltimore

State Registrar 29b. Signature and title of certifier

Marian Grant

31. Date filed (Month, Day, Year)

29c. License number

Towson

R149194

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM# 20a, b, per FH, G900, 2/25/2010, ws
State of Maryland / Department of Health and Mental Hygiene) | | | For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1:23 P M 20 2010 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year Months Days 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year 1 M 2 F Hours Min. 82 Yrs. Man 230-22-331 ept Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ahow is 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event. He Miscreal Examine must be not lifted at 1 Xes 2 No N Director altimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number grode USA 4606 2121 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify. Black 3 Noticed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Hopkins Laund College (1-4or 5+) abover Johns 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Maiden Sumame) Be 91 Mag Kobinson lhomas ٩ Pages 1 and 2 should permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret 4606 daughter Kelly Srode raltimore, 21214 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 2ate + Serial 2 Cremation 3 □ Removal from State ∕ Mecro crematory ∘ alti more 4 Donation 5 Other (Specify) 21. Signatur of uneral Service Lines Home 22. Name and Address of Facility Funera once Galtimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 the attending physician Completed by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Day be detached for Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗍 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Failur Tratory 2 No 3 Probably 1 🗌 Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 ₩o 2 100 1 ☐ Yes or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Cyntua on aus MO 2/2//10 00051347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Baltmar Mg 21204 Soriano MO Cynthia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23a Per dr., g900,02/25/2010dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 10:45 PM 18, 2010 Maria Papadopoulou Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1922 Midland Road Dundalk If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 216-13-6573 90 6-16-1919 Egypt Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Examinar must be notified at Director Dundalk YOYes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 1922 Midland Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ite Myonce. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Virginia Gerogiannis Demetrie Manias ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1922 Midland Rd., Dundalk, MD 21222 Virginia Bratsis-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Parial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus 2-24-10 22. Name and Address of Facility Bradley Ashton Funeral Homa 21. Signature of Funeral Service Licensee PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE RENAL **Physician** Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Years MONTHS Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Euro to for es a consecuence ofic Examiner and burial-trar Due to (or as a consequence of): だるがたし Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Dav Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBUARY 19, 2010 RES00-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN'S HOPKINS BAYVIEW MEDICAL CENTER, 4940 EASTERN DAVID CHANG, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 25

32 Registrar's Signatu

AVENCE , BACTIMURE MI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #9 Per ANA BD C 900 2/25/2010 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** William Fletcher Powell 2010 February 13 8:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8529 Stevenswood Rd. Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State of Foreign Northry CArolina Funeral Voar) Days 1 X M 2 □ F 219-10-9613 86 Director May 8, 1923 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show s 23a or 28a-f shortust be notified at 1 ☐ Yes 2√☐ No Director MD Baltimore Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 8529 Stevenswood Road 21244 USA Funeral Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, it is Medical Expoiling once. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 43-46 1 ☐ Never Married 2 X Married 1 □Yes 2 No Specify: Specify: black \$ 3 Widowed 4 Divorced Completed unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) steel worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Issac Forest Powell Hattie Whitehead ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8529 St4evenswood_Road_Baltimore, MD Leora Powell/spouse <u> 21244</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature — Euneral Service Licensee No. 1011711 S. Walle 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-tran and Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, physician attending pl Division of Vital Records, P.O. icate has been signed by the page 2 should be detached certificate this After t within 24 hours after deat To the Funeral Director: filled in by the

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

29a. Certifier (Check only one)	1 ← Certifying Physician: To the best of my knowledge, death occ ☐ Medical Examiner: On the basis of examination and/or investion and manner stated.	curred at the time, date and place, and due to to gation, in my opinion, death occurred at the time	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
29b. Signature and	the of certifier	29c. License number	29d. Date signed (Month, Day, Year)

FEB 25 2010

ed cause of death (Item 23)

31. Date filed (Month, Day, Year) Registrar's Signature

Medical

Johnnyboy Payo		y amend #\$ I-For State	eate of Mallyle		ર્જાતાં તે કે		and	Mental	Hygi		20	iΛ	05446
Physicia		Registrar 1. Decedent's Name (First, Mid	dle,Last)		tinouto or	Dodin				Date of Dea			3. Time of Death
Medical Exami		JOHNNY BOY I							F	donth ebruary			0857 hrs
		4a. Facility Name (if not institut 4229 58th Avenue	on, give street and nu	ımber)	- 1	tb. City, Town		cation of D	eath		4c. County of Prince Ge		's
- · · ·	-	5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1		If Under 24	4Hrs. 8.	Date of Bir	th(MM/DD/YYYY)		
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36 in 72 h han "r lical E	plet	Elementary/Secondary (0-12 1 1) College (1-4 or 5+)				DELI	VER	Y MAN	PRIV	AT	E
5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First, Middl	e, Last)	_			18	.Mother's N	lame (Fir	st, Middle, I	Maiden Surname)		
215 be filed atal Hy rked o	ക്	TOHN PAYOUV	JAY					LYDI.		-	LARK Re	gin	a Clarke
21 nould I is mar tic eve	٩Ì	19a. Informant's Name/Relation	ship (Type, Print)							I Route Nur	nber, City or Town	State,	Zip Code)
MD nd 2 sh alth and alth and an 27 is		LYDIA CLARK/ 20a, Method of Disposition	MOTHER	205	4811					LEXAN	NDRIA, N	/A.	22309 Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho injury or other traumatic event, the Medical Examiner must be notified at once.	-1	1 X Burial 2 Crematic	on 3 Removal fi	rom State	crematory or oth	ner place)	ERY	,			ALEXA	•	
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Physician	\dashv	28a. Part 1. Enter the dise se, of failure. List only of e caus	or complications that	aused the death	Op not enter the	ne mode of d	ying, su	ich as card	iac or res	spiratory arr	est, shock, or hear	1	Approximate Interval Between Onset and
Examiner	l	Immediate Cause (Final disease	01	monoxid	le toxio	ity						1	Death
Examine		or condition resulting in death)	Due to (or as a	a consequence o	of):								
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Box 68760 e death certificate the attending physical of for use as the bu	cian	23b. Was decedent pregnant in past 12 months?	LIVE	birth nant at time of de	anth -	tal death her (Specify	3 [_	Ectopic pr	egnancy		Month	D	ay Year
Box he death the atte	hysic	1 Yes 2 No 9 U	nknown 9 Unkn	own	0 01	ner (opcon)							
(\$\triangle \) Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the but	by P	Part II. Other significant cond	itions contributing t	o death but not r	esulting in the u	ınderlying ca	use giv	en in Part I				_	the cause of death? ably 4 Unknown
ords, w require is been sig	Completed									24a. Was	4		topsy findings available ompletion of cause of '
tal Records cian: The law requi certificate has been ector, page 2 should	ğ								_	autor perfo	rmed? de	eath? ✔ Ye	
tal Rec	ပို	25. Was case referred to medic	al			26 1	Place o	f Death (Ch	neck only		2 10 1	V 10	
Vita ysicia direct	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	0	ther N	ursing H	ome 5	Residence 6	Other	Scene
of Viving Physic	Ë	27. Manner of Death 1 Natural 5 Page		e of Injury h, Day,Year)	28b. Time of I			at Work?			how injury occurre		oxhoust
Sion strend death. ctor:	atic	Pe	Congunon	/7/10	Fd 8:15	am		s 2 X No	1		tion of c		ral Route Number, City
Division of Vital Records, ital or attending Physician: The law requir as after death. After this certificate has been so lited in by the funeral director, page 2 should	ertification:	de	uld not be termined (Specify	ce of Injury - At h parki	iome, farm, stree Lng lot	et, ractory, or	tice bui	iding, etc.	B	or Town, S	State)4229 5 sburg, MI	8th	Ave
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O	4 Homicide 29a. Certifier 1 Certifying	Physician: To the be		ige, death occur	rred at the tin	ne, date	and place					
o the lathin 2 o the lathin 2	Medical	one) 2 Medical Ex	caminer: On the basis and manner	of examination a	and/or investiga	tion, in my or	oinion, d	death occur	red at the	e time, date	and place, and du	e to the	e cause(s)
E 3 E 8	Ž	29b. Signature and title of certi					icense				29d. Date signe		
		(droe	Halli	xu			D.C.M	.E.			February 8,	2010	<u> </u>
		30. Name and address of personal Allan, MD A	on who completed cau		n 23a) 111 Penn :	Street. Ba	ıltimo	e, MD 2	1201				
	ate	31. Date filed (Month, Day, Yea	r) 32	egistrar's Signat	ure			.,					
Regist		FFR 9.5		asced A	1 bar	Kel							

0-01166		Please Type or Print in Black Indelil	ole Ink. Ensure All Copi	es Are Lec	rible.						
Ventley Grands	on	Roberts State of Maryland / Departme	nt of Health and Mental H	Ivgiene	2010	0544					
		1- For State Certifica	te of Death		ے کا 1 U g. No.	0044					
Physicia	an/	Decedent's Name (First, Middle,Last)		2. Date of Deat	h	3. Time of Death					
Medical Exami	nei	Wentley G. Roberts		Month February 8	Day Year 3, 2010	1902 hrs					
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dear		4c. County of Death						
√ ′		Johns Hopkins Bayview Medical Center	Baltimore			IA					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth				hplace (State or					
Director		218-42-7035 1₹Xm 2□F 64	Yrs. Months Days Hours Mi	05-22		untry) MD					
20		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town of									
ow any		100. 019, 104110		t.		10d. Inside City Limits					
Maryland 28a-f show	tor	MD NA Baltimore Baltim	Buildark			1 X Yes 2 No					
or 28s	Director	125 Oak Street	10f. Zip Code 21222	10	g. Citizen of What Coun	try?					
ith the 23a of notif											
ath w tems	Funeral	1 XX Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	specify Yes or No- o Rican, etc.)	14. Race - Americ	can Indian, Black, frican					
er de		1 Yes 2 No	1 Yes 2 X No specify:	,							
uraf	þ	or Dates:	ecedent's Usual Occupation (Give kind of	work down	Specify: Ame						
2 hox	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use re	tired)	16b. Kind of Business/Ir	ndustry					
thin 7	npf		fice Manager		Computer	Company					
5-0 ed wi stygies other he M	Comple	17. Father's Name (First, Middle, Last)		e (First, Middle, M	_						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Charles Roberts	Doreat		Teel						
22 hould hould Me is ma	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or	Rural Route Numb	per, City or Town, State,	Zip Code)					
Baltimore, MD 21215-0036 bermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinging or other traumatic event, the Medical Examiner must be notified at once			930 Westwood Av	enue Ba	ltimore,	MD 21216					
S and Free of Hear If ite			Disposition (Name of cemetery, y or other place)	I	20c. Location - City or 7						
Page Page nent ant:		4 Donation 5 Other Specify: Metro	Crematory 02	-20-10	Catonsvil	le, MD					
Baltimore, permit. Pages I an Department of Her Important: If ite njury or other tr		21. Signature of Funeral Service Licensee	22. Name and Address of Facility W	ylie Fu	neral Hom	e P.A.					
		Sumeda Jones.	638 N. Gilmor S	treet B	altimore,	MD 21217					
Physician /Medical	Ш	23a. Part I. Enter the disease, of complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and					
Examiner		Immediate Cause (Final disease a. Narcotic (morphine	and ethanol into	xication		Death					
		or condition resulting in death) Due to (or as a consequence of):									
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	틭	cause. Enter Universify Cause (Disease or injury that initiated c									
igi ed	Examiner	events resulting in death) Last Due to (or as a consequence of):									
executed an and al - transit	ह	X UNPENDED X AMENDED 101									
	Physician/Medi	1UD,c,12, pe	r FH, 23a,27,28a-f	permE,		0 TT					
ecords, P.O. Box 68760, he law requires that the death certificate be are has been signed by the attending physicing 2 should be detached for use as the buri	٤	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery						
ox 687 eath certification attending	icia	past 12 months?	Other (Specify)	aricy	Month Da	ay Year					
Bo e deat ed for	ly S	1 Yes 2 No 9 Unknown 9 Unknown		711							
P.O. s that th	by P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?					
S, P.C				1 Yes	2 No 3 Proba	ibly 4 🗸 Unknown					
ords w requi	Completed			24a. Was an		ppsy findings available mpletion of cause of					
teco	E			perform 1 Yes 2	ned? death?						
ital Recition: The sector, page	Bec	25. Was case referred to medical	26.Place of Death (Check		7 10 1 183	2 No					
5 % ≝ 7 l	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other Nursir	ng Home 5 R	esidence 6 Other:						
n of V		(Month Day Year)	ne of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred						
Division talor attendir is after death.	atio	Natural 5 Pending Fd 2/8/2010 unk	1 Yes 2 No	unk							
or A or A after of Direc	읣	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm	, street, factory, office building, etc.	28f. Location (Str	eet and Number or Rura	I Route Number, City					
Spital sours sours neral filled	Certification:	4 Homicide determined (Specify) house		Dundalk,	te) 125 Oak S	-					
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, and	due to the cause(s) and manner as stated	1.					
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical	and manner stated.	estigation, in my opinion, death occurred a	it the time, date an	nd place, and due to the	cause(s)					
	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	h, Day, Year)					
		unles	O.C.M.E.		February 9, 2010						
R	1	 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Pe 	nn Ctroot Deltimon has acces								
			nn Street, Baltimore, MD 21201								
Sta Registr	-	31. Date filed (Month, Day, Year) FEB 2 5 2010 32. R@istrar's Signature	parke								
DHMH 17 Rev 1/200	_	OPIG		OCME							

10-01166

	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No. 2010 0544								
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year February 22, 2010 3. Time of Death 1100 hrs								
production of the second	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2407 Steele Road 4c. County of Death Baltimore								
Funeral Director	5. Social Security Number 1 X M 2 F 55 Yrs. The security Number 2 Social Security Number 2 Social Security Number 3. Social Security Number 3. Social Security Number 4. Social Security Number 5. Social Security Number 4. Social Security Number 5. Social Security Number 6. Sex 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary Land								
72 hours after death with the Maryland n "matural", or items 23a or 28a-f show any al Examiner must be notified at once. eted by Funeral Director	United States 10e. Street and Number 2407 Steele Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollif Yes, Sive Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's United Divorced of Business/Industry								
5-0036 lled within Hygiene. I other tha the Medic	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Contractor Building Construction 17. Father's Name (First, Middle, Last) Edward Henry Redman Contractor Building Construction 18. Mother's Name (First, Middle, Maiden Surname) Shirley Ioleen Brown								
D 2121; should be fil is marked is marked atic event, I	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is in injury or other traumatic	Dr. Beverly Ann Redman / Sister 72 6th Avenue Collegeville, Pennsylvania 19426 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify: Date 20c. Location - City or Town, State 20c. Horning of Communication (Name of Cemetery) 20c. Location - City or Town, State 20c. Location - City or Town, State								
Balt permit Depart Import	21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231								
Physician 'Medical aminer	Approx 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx Between condition resulting in death) a. Atherosclerotic Cardiovascular Disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):								
red nsit Examiner	Sequentially list conditions, if any, leading to immediate cause Fact U depth of Course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
50, te be execut nysician and bunial - tra	d. UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specific)								
). Box 687(the death certifica by the attending pl ched for use as the	1 Yes 2 No 9 Unknown 9 Unknown								
cords, P.C law requires that has been signed to 2 should be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No								
Vital Recystrian: The his certificate director, page	25. Was case referred to medical 26.Place of Death (Check only one)								
ion of Virtuding Physicath. to: After this the funeral direction: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No								
Division o spital or Attending cours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Homicide Homicide 4 Homicide Homicide Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Fo the Ho within 24 I To the Fu completely	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 22, 2010								
	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registrar	31. Date filed (Month, Day, Year) FEB 2 5 2010 32. Registrar's Signature 4.								

			1 - For State Registrar	·	partment of Health and N <i>ertificate of Death</i>	, 0	0010	051.1.0
	Physic	an	1. Decedent's Name (First, Middle, Las	<i>t</i>)		2. Date of Death	<u> </u>	3. Time of Death
	Physic /Medi		Carrie	Stacy		Month D	Day Year 2010	9:15 AM
الممور	Examir Funeral Director	ner	4a. Facility Name (If not institution, give Season S 5. Social Security Number 6. Se	Hospice	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Bald 9. Birthp	MOTE lace (State or Foreign try)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		3.7.114011	Od Inoido City Limite
	he Maryla 28a-f shor		10e. Street and Number	A Ba	Himore			0d. Inside City Limits 1 ⊠Ves 2 □ No
	h with	a Di	903 Notting	han Pd Apt	10f. Zip Code	10g. C	Citizen of What Coun	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination until to neithed at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto □ Yes 2 □ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
21215-0036	within 72 hou ene. than "natura ne Medical E	Completed by	15. Decedent's Edu (Specify only highest grad	ucation 16a. Dec	cedent's Usual Occupation we kind of work done during most of work O NOT use retired)	ing 16b.	Kind of Business/Ind	acc justry
and 2	id be filed within lental Hygiene, ked other than " ic event, tre Me	To Be Col	17. Father's Name (First, Middle, Last)	lor	18. Mother's Name	e (First, Middle, Maide	uning F	nterprise
, Maryland	and 2 shoul saith and M n 27 is mar er traumati	ř	19a. Informant's Name/Relationship (7)	(pe. Print) (niece) 19b. Ma NES 90	iling Address (Street and Number or Run 3 Nottingham	al Route Number, City	or Town, State, Zip	Code)
Baltimore,	t. Pages 1 tment of He tant: If iten ijury or oth		20a. Method of Disposition 1	Mt. 2	position (Name of ematory or other place) -1 0 0	Date 20c.	Location - City or To	wn, State
Baj	permit Depar Impor any in	10	21. Signature Funeral Service Licens	Thouses J.M. 2	22. Name and Address of Facility 0 Seph L. Russ Fu 222 W. North Ave	·	e, P.A. Md. 2121	16
1	Physician /Medical		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not e ne cause on each line. End - Stage De		or respiratory arrest,	11	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequence of):				
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
68760,	rificate be executed ig physician and as the burial-transit	ledical Ex	resulting in death) Last	Due to (or as a consequence of):				
P.O. Box 6	Attending Physician: The law requires that the death certific at death. The factor. After this certificate has been signed by the attending pot the funeral director, page 2 should be detached for use as the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ry Day Year
ords, P	w requires that s been signed b should be deta	þ	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the	e cause of death? ably 4 Unknown
Division of Vital Records,	ician: The law r certificate has be ector, page 2 sh	Completed				24a. Was an autopsy performed?/	prior to com death?	sy findings available apletion of cause of
Ž	ysician: iis certific director,	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death		a Mari	. 11- 0
ion of	ending Physeath. or: After this he funeral di	⊢ ⊾	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	4 Nursing Hor	me 5 Residence 28d. Describe how inju		Hospice
N N	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Street a City or Town, Stat	e)			
	To the Hosp within 24 ho To the Fune completely f	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause(ed at the time, date an	s) and manner as stand place, and due to	ated. the cause(s)
	To t To t		29b. Signature and title of certifier 1/5/2/4/2009 M.D.		29c. License number D005 7 465	1 1	ate signed (Month, D	ay, Year)
	51		30. Name and address of person who co	2835 Smith AV. 5-20	3 - Baltimore, MD.	21209		
t	Stat	е	31. Date filed 18 25 2010	32. Registrar's Signature	2			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U | U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Daris Edsel 1:55P M 2010 Medical Feb 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol Carrol Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 **№** M 2 □ (Month Day, 236-54-147 76 Director WV Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Nicholas WV Nettie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 947 Alderson Rd. 26681 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 Married ģ 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 General Laborer Lumber Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Asa Stull Nettie Dorsey Stull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Sutton-daughter 186 Manon Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Arial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 2/25/2010 Nettie, WV 21. Signature of Funeral Service Licenses Fletcher Funeral Home 22. Name and Address of Facility Komas Z 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Equaritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated see of the cause) Examine and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed rtension that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown the r P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown of chronic disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s erlipideme 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case refered to media Be 26. Place of Death (Check only one) Hospice Hospital 2 No 1 🔲 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Spec After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: Aft oleted filled in by the fun Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 201 31. Date filed (Month, Day, State **FEB 25** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Physician SIMMS 5:10 PM 19 FEBRUARY 2010 1WENDOLYN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE KANDALLSTOWN NORTHWEST HOSPITAL 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funeral Hours Year) 1 □ M 2 🖫 F Months Days Director 212-20-2821 Apr 2, 1924 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it was death Experiment in at the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland **Baltimore** Randallstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9309 Tulsemere Road Funeral 21133 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐No δ Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Medical Researcher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Haywood Sr. Edna Havwood ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. Joyce Brice 9309 Tulsemere Road Randallstown, Maryland 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 02/26/10 Baltimore, Maryland Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease, or complications that caused tr shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATHY 2XNo 3 Probably 4 Unknown 1 Yes PULMONARY HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy FAILURE RENAL ACUTE 2 X No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical

P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed physician cate has been signed by the attending page 2 should be detached for use as certificate or Attending Physician: After death. within 24 hours after death

To the Funeral Director:
completely filled in by the f Hospital

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my existing death account of the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examin On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0060293 2010 FEBRUARY

30. Name and address erson who completed cause of death (Item 23a) (Type, Print)

OLD COURT ROAD, RANDALLSTOWN MD 21133 5401 AHMED, M.D

State Registrar

31. Date filed (Month, Day, Year) FEB 2 5 20 201



the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Detedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2 ERT 700 M 2010 /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 517 Hillsmere Drive Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F Months Days Hours Min. Director 218**-**42-8318 65 DEc 27. 1944 Maryland Usulal Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examination ust be notified at Director MD Anne Arundel 1∐Yes 2√∑No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 517 Hillsmere Drive 21403 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Example Once. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: \$ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Lewis Soeaks Marion Jay ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dyan Carol Speaks/spouse 517 Hillsmere Drive Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Ronald S . Wa 21. Signature of Puneral Servi 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the dis 4 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Approximate Interval Between M CN 175 Immediate Cause (Final Physician disease or condition resulting in death) GANCREA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. ☐Yes 2☐No the 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 🗹 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Z No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

FEB 25 2010

Year

441

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENTA

m

32. Registrary Signat

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUAR: : 53 PM 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMOR JOHNS HOPKINS BAY VIEW MEDICAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Hours Min. NoWorth Bay, Y12921 Demmark 88 **Director** 218-19-6618 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1X Yes 2 No Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral USA 21224 109 S. Linwood Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify white Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) waitress food industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Estrid Alfrida Nielsen Pedersen Soren Norgaard Jensen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
109 S. Linwood Avenue Baltimore, MD 21224 19a. Informant's Name/Relationship (Type, Print) Helle Desimone/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signalure of Funeral Service Lidensee State and Address of Facts board 655 W. Baltimore Street Virector 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC disease or condition resulting in death) MINUTES Medical Due to (or as a consequence of) Examiner BLEEDING STROIN TESTIN DAYS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Lue to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ASNER

25 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

-000

BALTIMORE, MD

29d. Date signed (Month, Day, Year)

2010

	State	partment of Health and N ertificate of Death		010 0515							
	1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No.	3. Time of Death							
Physiciar /Medica	Rootrico Chonn		Month Day February 15	Year 2010 9:05 PM ^M							
Examine	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		unty of Death							
	Chesapeake Woods Center	Cambridge		Oorchester							
Funeral Director	5. Social Security Number 6. Sex 1 M 2 X F 98 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreig Country)							
	Usual Residence of Decedent		Oct 2, 1911	Virginia							
ryland how	10a. State 10b. County 10c. City, Town or I	Location		10d. Inside City Limit							
e Ma	MD Talbot East	ton		1 ☐ Yes 2 X No							
vith the Mar	10e. Street and Number	10f. Zip Code	10g. Citizer	of What Country?							
s 23a		21601		USA							
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Exar, incr. rust by notified at To Bo Completed by Euroccia Discontinuation.		B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🎇 No Specify:	Rican, etc.)	Race - American Indian, Black, White, etc. ecify: White							
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filed within 72 hou Hygiene. Sther than "naturaint, he weden!	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) O	re kind of work done during most of work DO NOT use retired)	ing								
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ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic	George R. Shepp Jr/son M-7	ling Address (Street and Number or Rur Bear Mt P.O. Box	314 Bendervi	lle, PA 17306							
rages 1	20a. Method of Disposition 1										
permit. Page Department of Important: If any injury or once.	21. Signature Funeral Service Scensee Wades Director S	22. Name and Address of Facility tate Anatomy Board altimore, MD 2120	655 W. Balt:	imore Street							
Uncate be executed By physician and By the burial-transit By the b	Immediate Caul. (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	ey filese fibrillation	et dese	Onset and Death							
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ar this oral dir	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manper of Death 28a. Date of Injury 28b. Time of	THE SEL DOA 4 LANUISING HOL	me 5 Residence 6								
the street	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury oc	curred							
rs after death. al Director: After led in by the funera Certification:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street and Nu City or Town, State)	ımber or Rural Route Number,							
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dear (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause(s) and ed at the time, date and pla	d manner as stated. ce, and due to the cause(s)							
omple Mec	29b. Signature and title of certifier	29c. License number		gned (Month, Day, Year)							
> - 0	MAH. MA	062250	7 2/1	6/10							
	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	12/1	0110							
	MAHOURA ALHTER, 800	3 Bus Stut	· Ca. L. d	700 110-210							
State	31. Date filed (Month, Day, Year) 37. Registrar's Signature	and sure	1 comput	Te , MUNIO							
Registrar	FED 22 ZUIU CENUN D. GOD	West		,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9, 12:30 PM^M 2010 February Helen C. Schneider /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sandy Springs
If Under 1 Year | If Under 24 Hrs. Montgomery Friends Nursing Home 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, June 13, 1 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days New York Hours 1 □ M 2 🕅 F 98 1911 Director 324-42-3846 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No MD Montgomery Sandy Springs Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 20860 USA 17401 Norwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊟Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white Be Completed by 3 X Widowed 4 ☐ Divorced UHE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic eve Bertha Lang Clyde Curtis ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19939 106 Vines Lane Dagsboro, DE Nancy Purchase/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 → Other (Specify) State and Address Board 655 W. Baltimore Street 21. Signature of Funeral Service Sicen No de Director Baltimore, MD 21201 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or gart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NANITION /Medical Due to (or as a consequence of): Examiner 3 EWEM. Sequentially list conditions, if any, leading to him solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transit MUNDENY and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2**X**No 3 □ Probably 4 □ Unknown 1 🗌 Yes bestill Dewig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 25No Vital director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Divising Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes > No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 0 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Division 1 Natural 5 ☐ Pending investigation n 24 hours after death.

Re Funeral Director: Af olderely filled in by the full 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

completely within 2 the

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

· GLANC.

FEB 25 2010

DHMH 17 Rev 1/2001

MD

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

BRIGGS CHANGY

29d. Date signed (Month, Day, Year)

575-11-6

SILVER

10-01287 Mary M. Schafer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 05455

	1- For State Registrar			Certii	ficate of L			incar i iy	_	eg. No.	
Physician/	1. Decedent's Nar	ne (First, Middle,Las	st)		-				. Date of Dea	th	3. Time of Death
Medical Examine	MARY-MA	RKELLA SC	HAFER						Month February		1342 nrs
		(if not institution, giv hire Road #102	e street and number)			. City, Towr Rosedal	, or Location	of Death		4c. County o	
Funeral	Social Security			e (In yrs. last		If Under 1		der 24Hrs.	8 Date of Bir		9. Birthplace (State or Foreign
Director	216-66-		M 2 XF				Days Hour	rs Min.			Country)
_	Usual Residence		JWI ZLAF	57	Yrs.				MAY 9.	1952	MD
any	10a. State	10b. County		10c. City, To	wn or Location	1				_	10d. Inside City Limits
Maryland 28a-f show 1 at once. ector	MD	BALTIM	ORE	ROS	EDALE						1 Yes 2 No
the Maryland a or 28a-f sh	10e. Street and No				1	10f. Zip Coc			10	Og. Citizen of Wha	at Country?
_ 2 2 2 2 1 _		INTSHIRE	KD		21237 USA						
or death with	11. Marital Status	ied 2 Married	12. Was Decedent Armed Forces?				Hispanic On ban, Mexicar		cify Yes or No	14. Race - White,	American Indian, Black,
er death witems r must be Funera	3 Widowed		1 Yes 2	X No					iodii, cic.,		, 610.
ural" ural"	15.0	4 X Divorced	or Dates: nly highest grade com	inleted) 16	a. Decedent's		No specify.		t done	Specify: 16b, Kind of Bus	WHITE
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Sec		College (1-4 or 5				life. DO NOT			Tob. Killa of Bus	iness/industry
036 ithin 7 ne. r than			4+		NURSE					HEALTH	CADE
5-0 led w other other		(First, Middle, Last)					18.Mother	r's Name (F	irst, Middle, M	laiden Surname)	CARE
121 d be fi ental l arked arked vent,						-		TY LE			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by F		ame/Relationship (T SCHAFER-									, State, Zip Code)
and 2 ealth tem 2 traum	20a. Method of Dis		50N	20b. Plac	5003 e of Dispositio	RAIN'	Cemetery	AY AP'	T H BA	ALTIMORE	MD 21206 City or Town, State UNK.
ore ges 1 tof H tof H			Removal from Sta		natory or other	place)	UNK.	,	odic OIVIC .	Zoc. Location - C	only of Town, State UIVK.
Baltimore, bernit. Pages 1 ar Department of Hee Important: If itee		Other Specify:			22 Nom	o and Add					
Ba Derm Depa Impo	1 011		Sec .		6/1	le and Addr 15 RET	ATD DI	MTLL]	ER-DIPI	PEL FUNE E, MD 21:	RAL HOME, INC
Physician	23s. Par I. Enter t	ease, or comp	lications that caused t	the death. Do	not enter the	mode of dyi	ng, such as c	cardiac or re	espiratory arre	st, shock, or hear	t Approximate Interval
/Medical	Immediate Cause	e cause on ea	chline. Acute hem	orrhad	ic leul	coence	enhalit	tis			Between Onset and Death
Examiner	or condition resulti		Due to (or as a conse		10 1001	to circ t	phall	<u></u>			
<u></u>	Sequentially list co		Due 45 / 55 - 55 - 55 - 55 - 55 - 55 - 55 -								
nine nine	if any, leading to in cause. Enter Under (Disease or injury t	erlying Cause	Due to (or as a conse	quence or):							
ted Insit Examiner	events resulting in		Due to (or as a conse	quence of):							
760, ficate be executed g physician and the buntal - transit	CTUNIDENIDED	d			-		_				
760, icate be execu g physician and the burial - tra	XUNPENDED		AMENDED 23a,	27,per	ME g90	$01 \ 3/2$	22/10 7	ΓT			
1876 rtifica ing ph as the	23b. Was decedent past 12 months	pregnant in the	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy					23d. Date of de Month	elivery Day Year		
Box 687 e death certific the attending ed for use as t hysician/	1 Vac a .	vi No 9 ✓ Unknown	4 Pregnant at t	ime of death		(Specify)					,
D. Bc t the dez by the z ached fc			9 Unknown						lee But		
Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the d is after death. After this certificate has been signed by the led in by the funeral director, page 2 should be detached erification: To Be Completed by Physicians: To Be Completed by Physicians.	Part II. Other Signi	ricant conditions	contributing to death	but not result	ing in the unde	erlying caus	e given in Pa	art I.	23e. Did tob		ute to the cause of death? Probably 4 Unknown
Records, P The law requires t ficate has been sign, page 2 should be e							<u> </u>		24a. Was a		ere autopsy findings available
Corc law re has be 2 sho									autops	y prio	or to completion of cause of ath?
tal Rection: The certificate ector, page									1 ✓ Yes 2		Yes 2 No
iciam s certi	25. Was case reference examiner?		ospital:		0		Other				
n of Viding Physical After this funeral direction:	1 ✓ Yes 27. Manner of Deat	2 No	28a. Date of Injur	/ 28h	Outpatient 3 Time of Injur		njury at Work?	Nursing H		esidence 6	
on	1X Natural	5 Pending	(Month, Day, Yea	ar)	. Time of injur	1	Yes 2		u. Describe no	w injury occurred	
vision or Atten frer death frer death Director: in by the	2 Accident	Investigatio	28a Place of Init	ry - At home,	farm, street, fa	actory, office			Location (St	reet and Number	or Rural Route Number, City
Division o spital or Attending ours after dear neral Director: After filled in by the fune	3 Suicide 4 Homicide	6 Could not b determined	e			,,,,,		1	or Town, Sta		or real reside realiser, only
Hosp 24 ho Fune rtely fi	20a Ca#iCa#	Certifying Physicia	n: To the best of my	knowledge, d	eath occurred	at the time,	date and place	ice, and due	e to the cause	(s) and manner as	s stated.
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as I Medical Certification: To Be Completed by Physician	one) 2 🗸	Medical Examiner:	On the basis of exami and manner stated.	ination and/or	investigation,	in my opini	on, death occ	curred at the	e time, date ar	nd place, and due	to the cause(s)
Ž	29b. Signature and	title of certifier		-1			nse number			29d. Date signed	(Month, Day, Year)
	all	w	M	\prec		0.0	C.M.E.			February 13,	2010
NV			ompleted cause of de	1,000			in a	4D 04==			
	Zabiullah Ali 31. Date filed (Mont		tant Medical Exa		I11 Penn S	treet, Ba	utimore, M	/IU 21201	l 		
State Registrar		FR 2.5 20	32. Registrar's	Signature	La	41					
DHMH 17 Rev 1/2001			IV JUDICION	O.	RIGINAL						

		For State of Ma		Department of I		ental Hy	giene	0 0010
		1 State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Death		Reg. No. CUIL	1 0040
Physic		Robert Thomas Tillman				2. Date of Dea Month	Day Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give street and number)		4h City Town	or Location of Death	teb	14 2016 4c. County of Dea	
LAGIII	ilei	SINAT HOSPITAL of	BAlti		RAltimo	Re GT	N/A	auı
Funeral	Г		ge (In yrs. last birt	thday) If Under 1 Year		8. Date of Birtl	h 9. Bi	rthplace (State or Foreign
Director		214-20-8884 ^{1໘M 2□F}	81	Yrs. Months Days	Hours Min.	(Month, Day	r, rear) C	rginia
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Maryl f sho	jo	Maryland N/A		ltimore				1√⊒Yes 2 □ No
r 28a	Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	
h with		11 W. 20th Street Apt.	17N		21208		USA	, .
ems ems	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of I	lispanic Origin? (Spec	cify Yes or No-	14. Race - Am	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modral Examinar must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes X☐ No		ilcan, etc.)		_{te, etc.} ack
72 h	ete	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of working	7	16b. Kind of Business	/Industry
within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5		life. DO NOT use retire Custodian	d)		Church	
filed Hygi Sther ent,		17. Father's Name (First, Middle, Last)			18. Mother's Name	First Middle	Maiden Surname)	
rdid be fental rked o	To Be	Philloyd Tillman			18. Mother's Name Rosa B.	Carte	r	
shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street	and Number or Rural	Route Number	r, City or Town, State,	Zip Code)
and 2 and 2 ealth n 27 i		Rosa Griffith/ Sister	54	Mailing Address (Street 30 ParkHe	ights Ave	enue B	altimore 6	,MD 21215
Jes 1 tof H if iter		20a. Method of Disposition 1 反 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery	y, crematory or other place	ce) 3/3/1°	ľ0 l	20c. Location - Oily of	Town, State
tmen tmen tant:		4 Donation 5 Dother (Specify)	Garris	on Forest	Vet. Cer	n. O	wings Mi	lls, MD
permi Depar Impor any Ir		21. Signature of Jonesal Survivor Inspec		22. Name and Address 5240 Rei	ss of Facility Chat sterstown	tman-H n Rd B	arris Fu Baltimore	neralNome ,MD 21215
		23a. Part Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	1e.					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	20501	erotic	Hearl	Dise	PasE	Onset and Death
/Medical Examiner		Due to (or as a	a consequence of	f):				
	er	Sequentially list conditions, b.	a consequence of	60				
uted	Examiner	Cause (Disease or injury	z ochacquones of	1/-				
exectan an anial-tra	Exa	routing is death) lest	a consequence of	f):				
ificate be executed g physician and ss the burial-transit	edical	d			_			
. = ⊙, α		IF FEMALE:						
eath certific attending p for use as t	sician/N	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 ☐ Ectopic pregnanc	У		23d. Date of de	
he de the s	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time of death	5 ☐ Other (specify)			Month	Day Year
that the led by detac	/ Phys	Part II. Other significant conditions contributing to death but	ut not resulting in	the underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
puires n sign	Completed by	HyperTension		, ,			s 2□No 3□P	
aw rec s bee	lete					24a. Was ai	24h Woro 21	utopsy findings available
The Is	mo					autops perforn	y prior to death?	completion of cause of
stan: ertifice ctor, p	Bec	25. Was case referred to medical			26. Place of Death (1 □Yes 2 Check only on		2 No
hysic this ce	2	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	nt 2 ER/Out	patient 3 DOA Other	35:		nce 6 □ Other (Spe	cify)
ing P	ii o	27. Mannef of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injur (Month, Day)	ry 28b. Tir (<i>Year</i>) Inj	ury Worl			w injury occurred	
ttend death stor: /	cati	2 Accident investigation			Yes 2 □No			
or A after Direc	Certification:	4 Homicide determined 286. Place of Inju- building, etc.	ry - At home, farn . <i>(Specify)</i>	n, street, factory, office	28	f. Location (Sti City or Town	reet and Number or Ri , State)	ural Route Number,
spita nours neral	O B	29a. Certifier 1 Certifying Physician: To the best o	f my knowledge.	death occurred at the tir	ne, date and place, an	id due to the co	auso(s) and manner a	c stated
To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner state	examination and	or investigation, in my o	pinion, death occurred	at the time, da	ate and place, and due	to the cause(s)
To To COT	Σ	29b. Signature and title of eartifier		29c. License	-		9d. Date signed (Mont	h, Day, Year)
		> rest of me			32272	> [eb 14,2	-010
		30. Name and address of person who completed cause of de	ath (Item 23a) (T		- 11	Tal	I DALL	imore
Stat		TREDERICK T-BURKE S 31. Date filed (Month, Day, Year) 32. Registra.	r's Signature	SINAI	Hospi	171 0	DAII	1171 UKC
Registra		FEB 25 2010 Centur	1. 1	all				
			-					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** TURNER 1300 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1864 If Under 1 Year If Under 24 Hrs. 2ACL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 💢 F Months Days Hours Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantion and the condition at Director 1 Yes 2 No ANNE 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDICATION permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be MHEELIER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (ources 4 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Ö 9 Unknow been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performed? Yes 2 No Vital 1 □ Yes 1 ☐Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Other: 4 \sum Nursing Home Medical Certification: To After this funeral dir 5 Residence 6 ☐ Other (Specify) ō 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 ☐ Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 039505 on_M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 23a) (Type, Print) Dr. Glen Burnie, S V

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

udhish Markan 305

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9155 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Joseph Richey Hospice, Inc 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔽 F Months Hours Director 217-38-4955 Dec 17, 1939 Maryland Usual Residence of Decedent or 28a-f shov 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🕇 Yes 2 🗆 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a of the Medical Examiner must be Funeral 3326 Ingleside Avenue 21215 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mercy Hospital Nurse's Aide Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ David Rogers Lillian Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3326 Ingleside Avenue Baltimore, Maryland 21215 Wilbert Thompson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 03/04/10 4 Donation 5 Other (Specify) Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A Eutaw Place Baltimore, Md 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for that the death Month Year Pregnant at time of death Dav 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ CHF The law requires 3 Probably 4 Unknown Records, Completed 1 Yes 2 No DM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 1 🗌 Yes 200 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 - Pending 1 🗌 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier HOD64267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 31. Date filed (M State Registrar's Signat Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 20:08 Jerome H.Williamson 2010 FRESTUGE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Singi Hospital of Baltimore Social Security Number 6. Sex 1 Ø M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth Months Days Hours Min 3-27-1947 Year) 218-36-4813 Director 67 Usual Residence of Decedent ıral", or items 23a or 28a-f shov I Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No MDBaltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3507 Cornstream Road 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates specify: African-American 3 Widowed 4 XXivorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) artment of Health and Mental Hygiene. ortant: If item 27 is marked other tha injury or other traumatic event, the N Educator **Baltimore City** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hezekiah Williamson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. once. Eunice Wilkerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly J. Williamson/Son <u> 3 redleaf Rose Court, Reisterstown</u> MD 211.36 20a. Method of Disposition Fintantment

Cremation 3 | Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) Woodlawn cemetery 3-1-2010 Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wile Fine P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sepsig adgus resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No signed by the a Id be detached f certificate has been si rector, page 2 should I

Physician/ Medical Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

with the Maryland

"natural".

should be filed and Mental H

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

3

Completed by Be မ Certificate:

Medical

(Check

only one) 29b. Signature and title of certifie

9 🗌 Unknown	9 LJ Unknown							
Part II. Other significant condition	contributing to death but not resulting in the underlying cause given in	Part I. 23e. Did tobacco use contribute to the cause of death?						
End stage renal disease	in pertension in pothyroidism	1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown						
		24a. Was an autopsy performed? 1 ☐ Yes 2 🗗 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🛣 No						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4	□ Nursing Home 5 □ Residence 6 □ Other (Specify)						
27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga		28d. Describe how injury occurred 2 □ No						
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e Place of Injuny - At home form etroot factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 Certifying F	sician: To the best of my knowledge, death occured at the time, date	and place, and due to the cause(s) and manner as stated.						

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day. Year.

February 21 2010

29c, License number

RES -000

To the Funeral Director: ocmpleted filled in by the State

24 hours

stad source of death (Itam 22a) (Time Driet 30. Name and address of person who cor Pamela Damisse 31. Date filed (Month, Day, Year) FEB 25 2010

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7	32.	. Regi	strar's S	Signat	ure	10	•

Registrar

	State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg No 2 0 1 0 0 5 4 6 1											
			Decedent's Name (First, Middle,	Last)		Timeate of L	- Jealii	2. Date of De	Reg. No.	3. Time of Death		
	Physicia Medi		John	William	Wilson			Month 02	Day 2	Year 010 14:39 FM		
	Examiner 4a. Facility Name (if not institution, give street and num					4b. City, Town, or		ath	4c. County of			
-	Funeral	_	Union Memori 5. Social Security Number		(In yrs. last birthday)	Balti If Under 1 Year	more	rs. 8. Date of Bi	Baltimo	O Birthmines Ottober 5		
	Director	ı	190-28-9764	1 kg M 2 □ F 7 4	Yrs.	Months Days	Hours Mi			Country) PA		
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				104 leader 02-1		
	larylar 3a-f sl ified	Director	PA		Hanover	oaton				10d. Inside City Limits 12√ Yes 2 □ No		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	흐	10e. Street and Number			10f. Zip Code	_		10g. Citizen of Wh			
		Funeral	191 Valley V			1733			US ———			
' 0	or iter	by Fu	11. Marital Status 1 □ Never Married 2 ※ Marri	12. Was Decedent Ev Armed Forces? C ed 1 2 Yes 2 1		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Black,	American Indian, White, etc.		
036	rs afte rral",	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White		
15-0	72 hou "natu edica	Completed	15. Decedent (Specify only highes	's Education	16a. Dece	dent's Usual Occupa		orkina	16b. Kind of Busi	ness Industry		
712	ithin iene.	Con	Elementary/Seconday (0-12)	College (1-4 or 5- 2	H) life. D	ONOT use retired) ger - Soc	_		Govern	ment		
ρc	filed wall Hyg	Be	17. Father's Name (First, Middle, La		<u> </u>				Maiden Surname)			
ylaı	lid be Menta narkec	မ	Evans B. Wilson					eth Fish				
Baltimore, Maryland 21215-0036	d 2 shou alth and 27 is n		19a. Informant's Name/Relationshi Carol J. Wilson		19b. Maili 191 V	ng Address (Street a alley Vie	and Number or F w Drive	Rural Route Number • Hanove	er, City or Town, Stat	re, Zip Code) 331		
ore,	of Hear fitem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	Data	20a Lagation Ci	hu av Taura Ctata		
tim	trent trent tant: I		1	ecify)	Wards Ch.	UMC Ceme	tery Fe	b 26 2 0 10	Randall:	stown, MD		
Baj	permit Depar Impor any in	78	21. Signature of Funeral Service Lid	14 Call	9	1212 West	Old Li	berty Roa		ral Home eld, MD 21784		
			23a. Part . Enter ne disease, or o shock, or healt failure. List on	omplications that caused by one cause on each line.	he death. Do not ente	er the mode of dying	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between		
	Ph_sician/ Medical	3 %	Immediat Cause Final disease of condit in resulting in the final res	a. Aortic	consequence of):	515				Onset and Death		
-4	Examiner			(over	ory Arter	y Diseas	2.					
	uean cennicate be executed ne attending physician and ed for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	ence of):						
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09		dical		d	consequence of):							
876	ifficate ng phy as the	Med	IF FEMALE:	_ u								
Box 687	eath certifice attending p	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	Fetal death 3	I death 3 Dectopic pregnancy				23d. Date of delivery		
O C O C C C C C C C C C C C C C C C C C									Month	Month Day Year		
O	that the ned by e deta	by PI	Part II. Other significant condition	s contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?		
ds,	quires en sig ould b	ted						1 🗆 🕆	Yes 2□No 3[Probably 4 Unknown		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1								 autopsy prior to completion of cause of 				
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of '	ng Phy ter this neral c		27. Manner of Dea h	28a. Date of injury (Month, Day,	28b. Time of	28c. Injury	at		lence 6 Other (Some own injury occurred	Specify)		
ion	tendir death. for: Af the fu	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	tion	nijary	M 1 □ Y	∕es 2 □ No					
Division of Vital	after d Birect Jin by	Ser	4 Homicide determin		/ - At home, farm, stre (Specify)	et, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ospita hours ineral d fillec	edical	29a. Certifier 1 Certifying P	hysician: To the best of m	y knowledge, death o	ccured at the time,	date and place,	and due to the cau	use(s) and manner as	s stated.		
1	hin 24 the Fι πplete	Σ	only one) 3 Certifying N	miner: On the basis of exa urse Practioner: To the be	mination and/or invest	gation, in my opinion	i, death occurred	at the time date a	ad place and due to	the cause(e) and manner stated		
	S 5 × 5 S		29b. Signature and title of certifier	MO.		29c. License	number 243894		29d. Date signed (M			
Ź		}	30. Name and address of person wh		th (Item 23a) (Tune P		-13014	6	02/22/2	010		
\ 			MANSOOR	MOZAYAN .	Union N	lemond t	holymal	Bally	nore, MD	21218		
	State Registra	e	31. Date file FEB, 25°201	32. Registrar's	Signature park	1	•		- /			
	negistra	•		<u> </u>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Sylvia Alice Walton рм /Medical February 19, 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heart Homes Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🗙 F Hours 544-28-7184 84 Oct. 10, 1926 Director ND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD Anne Arundel Linthicum 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 804 Camp Meade Road 21090 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ould be filed within 72 hours after Mental Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Administrative Officer Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gunnar Hanson Inga Sorenson Pages 1 and 2 should injury or other traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Charles O. Walton / Son 114 Linwood Avenue, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 Removal from State Final Journey Crem. 2/22/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service License Dorota Marshall W. Marsha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No 1 🔲 Inpatient ၉ 2 ER/Outpatient 3 DOA completely filled in by the funeral after death. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Datural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

D

State Registrar 29b. Signature and title of certifie

Day, Year)

FEB 25

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Mad

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Eston Coyner Wyatt February 15 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2802A Kings Ridge Rd. Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 X M 2 □ F Sept 7, 92 236-14-4468 Director 1917 WEst Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprirer must be notified at once. 10a. State 10h County 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 No Completed by Funeral Director MD Baltimore **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2802A Kings Ridge Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white 3 Widowed 4 X Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) transporter healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive Palmer Elam Clay Wyatt ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802A Kings Ridge Road Baltimore, MD 21234 Margaret Davison/former spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service RONALO State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) DISEASE ATHEROSCLEPOTIO HEART **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit DIABETES Due to (or as a consequence of): P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ MENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9105

32. Registrar's Signatur

29c. License number

D4000

FRANKLIN SQUARE

29d. Date signed (Month, Day, Year)

BALTIMORF, MD

DR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WOLF RICHARD ZO10 11:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ELLICOTT CITY HEALTH & REHAB CENTER HOWARD ELLICOTT CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1728/1914 101-32-3539 96 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No MD HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ural", or items 23a o Examiner must be by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 3000 NORTH RIDGE ROAD 21043 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" Specify: Completed 3 X Widowed 4 Divorced Year or Dates it of Health and Mental Hygiene.
If item 27 is marked other than "natu
or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) PHYSICIAN MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LESTER WOLF **FLORENCE LEOPOLD** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD WOLF, JR./SON 7104 BLACK ROCK COURT, COLUMBIA, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 X Removal from State SPRING GROVE CEM. 4 ☐ Donation 5 ☐ Other (Specify) 2/25/2010 CINCINNATI, OH 21. Signature — Fun ral Service Acensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIOPULMONARY ARREIT disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CONGESTIVE Sequer tfally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit HYPERTENSION death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CAROTID ARTERY SIEMOSIS Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 No signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DYSLIPIDEMIA cate has been signated bage 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/12No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 2 10 Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my printed death. 29a. Certifier The certifying Prysician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KATTI DESMI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

MAIDIZYHCI

3290 N.

Pagistrar's Signature

29d. Date signed (Month, Day, Year)

Ellicott Gty

0062704

Road

Ridge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #9 per FH g901 3/2/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1225 **Physician** Month asin 2010 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of maryland Med Cota University Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 **5** M 2 □ F Months Min. Hours 7702 Director Maryland 2010 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show Baltimore 1 Tyes 2 No Director ud 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21202 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u></u> Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Item Elementary/Secondary (0-12) College (1-4or 5+) 14 0 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ mpse 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street, and Number or Rural Route Number, City or Town, State, Zip Code) Amber N 21202 1312 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Line 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart congenital obsease **Physician** /Medical Due to (or as a o insequence of): Examiner Risomy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) the detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To n 24 hours after death.

ne Funeral Director: After th bletely filled in by the funeral 27. Mann r of Death 1 Vatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 1174725071 leb 192010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65.1 CM (MCM) Baltimore, MD Janell Alden Sherr, 22 S. Greene St. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State FEB 25 backs Registrar

DHMH 17 Rev 1/2001

Please Type or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible

			State of Maryland / Department of		ental Hygien	ne		
			1 - State Certificate	of Death	Reg. N	··2010 05466		
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death		
1	/Medic		Frymg K Becker		BRUARY 1	8 2010 11:51 TM		
	Examin	er		n, or Location of Death	4	Ic. County of Death		
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Vi	ear If Under 24 Hrs.	3. Date of Birth	9. Birthplace (State or Foreign		
П	Funeral Director			ays Hours Min.	(Month, Day, Yea 9 - 3 - 191	Country) N.J.		
			Usual Residence of Decedent					
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	Ba-f s	cto	MD. CHARLES WALDOR	F		1 □Yes 24 □ No		
	or 28	Director	10e. Street and Number 10f. Zip Co			Citizen of What Country?		
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dieal Evan in ar must be notified at	ral	2199 NEVILLE COURT 2	0602		S.A.		
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specify	of Hispanic Origin? (Spec Cuban, Mexican, Puerto R	ify Ye's or No- ican, etc.)	14. Race - American Indian, Black, White, etc.		
36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 No ARMY 1 Yes 2 WII 1 Yes 2 WII 1 Yes 2 WII	No Specify:		Specify: WHITE		
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual O			Kind of Business/Industry		
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nd	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (
yla	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, tha Madical Experimental be notified at	မ				FREDERICKS		
Nai	12 sho		1 1 2 1			y or Town, State, Zip Code) F, MD, 20602		
e, e,	1 and 2 Health em 27 i	10.13	BARBARA MAZOR-DAUGHTER 2199 NEVI 20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery, crematory or other	LLE COURT		Location - City or Town, State		
no n	ages ent of t: If it		# Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Cemetery, ciematory or other RESURRECTION		010 CT.	INTON, MD.		
Baltimore, Maryland	permit. Pages 1 Department of t Important: If ite any Injury or ot once.			ddress of Facility	010 CH	INTON, FID.		
ñ	Depa Impo any I		RAYMON	D FUNERAL	SERVICE	, P.A.		
	>		23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	ΤΑ ΜΑΡΥΙΑΝ f dying, such as cardiac or	respiratory arrest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	2001 8	undra	Onset and Death		
1	/Medical		resulting in death) a. Due to (or as a consequence of):	und -	your	21115		
	Examiner		Sequentially list conditions.	est		Immediate		
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
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cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
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	ires tha signed I be det	1 ☐ Yes	co use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 🖫 🖟 Known					
Ö	w requir been s should	eted			8			
3ec	e law has l	Completed			24a. Was an autopsy performed:	24b. Were autopsy findings available prior to completion of cause of death?		
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₹	sicla certi) Be	25. Was case referred to medical examinor? 1 □ Fes 2 □ No Hospital: 1 □ Inpatient 2 □ Fl/Outpatient 3 □ DOA	26. Place of Death Other:		6 ☐Other (Specify)		
ō	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c.	4 Traising Hom	Bd. Describe how in			
on	nding ath. r: Afte e fun	atio	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation M					
3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Ro.								
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	ical	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				
	the thin 2 the mple	29a. Certifier 1 Certifying Mysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Mysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)						
	5 <u>₹</u> ₹ 8		250. Signature and the or spring	00//0/01/01	2001	2-10-10		
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	CO GU BU 4	0	x-10-10		
			Dichard Ferran Chista	Hospital	Emerc	sency Department		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar' Signature	as A	(
	Registr	ar	FEB 25 2010 Genera B. Jan					

17 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Feb 5, 11:50 A M Margaret C. Bowie 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 219 48 4381 29, 1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits 1 □Yes 2 XX Director Sussex Laure1 Delaware 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9872 Loblolly Ave 19956 United States Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Race - American Indian, Black, White, etc. 7 is marked other than "natural", or iten traumatic event, the Medical Experien 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 📆 📢 o Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Kidwell Janie Mary Boswell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Margie Hight (daughter) 8814 Andrew Drive, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 12, 2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery | Cliffon, Maryland 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 23a. Frt1. Enter the disease, or complications that caused life the Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) HEMOREHAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 ☐Yes 2 ☐No 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ✓ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 至 ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar

Baltimore, Maryland 21215-0036

2010

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12/29/193

DaB

Margaret

Box 68760,

Ö

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

65TH

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Waryland		rtificate of			Reg. No.	Z 11 1 11	05!	468
	Physicia	an	1. Decedent's Name (First, Middle, La.				Date of Death Month Day Year		y Year	3. Time of E	Death	
	/Medic		Charles Layfette		:.			Februa	ry 6	2010	09:57	M
	Examin	er	4a. Facility Name (If not institution, given 55 S. Potomac St.		4b. City, Town, or Location of Death Hagerstown				County of Death shington	County	7	
-35	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	9. Birth	place (State or	
	Director		217-02-0900	XIM 2□ F 77	Yrs.	Months Days	Hours Min.	April	18,19	9. Birth Cou Mary	Tand	
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City	y, Town or Lo	cation					I 0d. Inside City	y Limits
	Maryl F sho	ţō	Maryland Washingt	on County Ha	gersto	wn					1X Yes	2□No
	h the or 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Cou	ntry?	
	ath wif	Funeral Director	55 S. Potomac St.	Apt 302		21740			U.S	S.A.		
	er des items	une	11. Marital Status	12. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2 ☒ No	S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))-	 Race - Ameri Black, White, 		
336	s filed within 72 hours after death with the Maryland al Hyglene. other than "natural", or items 23a or 28a-f show vent, the Mydical Even increment by nutilised at	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2XINo	Specify:			Specify: Whi	te	
5-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	nation	ina	16b. Ki	ind of Business/In	dustry	
7	Ithin 7	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	Painte		during most of work d)	ing	C . 1 4	f Formlan	لہ	
N	iled w Hygie Iher tl nt, In	S	17. Father's Name (First, Middle, Last)		rainte	= L	18. Mother's Name	(First Middle		f Employ	ea	
land	d be fental ced or	To Be	Roy Babington				Ruby K1			,		
ar	shoul and M s mari umati	Ě	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street	and Number or Run				Code)	
, mar	and 2 ealth a n 27 is		Hazel M. Babingto	n-wife	_55 S.	Potomac	St.Apt 3	02 Hage	ersto	own, MD	21740	
o e	t of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			sition (Name of natory or other plac		Date		ocation - City or To	·	
E	t. Pag rtmen rtant: njury		4 □ Donation 5 □ Other (Specify	y) Smi			ory 2-9-2		Smit	thsburg,	Maryla	ind
10a. State 10b. County 10c. City, Town or Location 10d. Maryland 10d. State 10d. County 10d. City Town or Location 10d. Zip Code 10d. Citizen of What County 10d. Zip Code												
			23a. Part 1, Enter the disease, or com	olications that caused the death		1331 Eastern Blvd. North Hagerstown, Do not enter the mode of dying, such as cardiac or respiratory arrest,					Approximate	
	Physician	(shock, or heart failure. List only immediate Cause (Final	one cause on each line.	(C .			,	1	Interval Betw Onset and D	eath
	Physician immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
	Examiner		Sequentially list conditions									
	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undorlying Cause (Disease or injury that initiated events resulting in death) Last	uence of):								
	execut a and al-tran	хап	that initiated events resulting in death) Last	c	ience of):							
οα / ο υ,	e be e											
Q	rtificat ng phy as th	Medical	IE SEMANE									
Ž Q	ath ce ttendii or use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar	death 3 [Ectopic pregnanc	y		2	23d. Date of deliv		
5	he dea the a	Physician/	1 Yes 2 No	4 ☐ Pregnant at time of do 9 ☐ Unknown	eath 5 🗆	Other (specify)				Month Day Year		
Γ.	that the by detac		Part II. Other significant conditions of	ontributing to death but not resu	Ilting in the ur	nderlying cause give	en in Part I.	23e. Did t	tobacco u	use contribute to t	he cause of de	eath?
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Ĭ	The late has page	The self of the se								use of		
1 Yes 2 1 Yes 3 Yes 4 Yes 4												
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Sion	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Worl	yat <br Yes 2 □No	28d. Describe	how injury	y occurred		
Due to (or as a consequence of): Comparison of the content of t								d Number or Run	al Route Numb	per,		
)				
	Hospi 4 hour Funer tely fill		(Check only 2 ☐ Medical Exan	niner: 🕅 the basis of examinat	wledge, death	occurred at the til	me, date and place,	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)				
	o the nithin 2 or the Smple	Medical	29b. Signature and title of certifier	and manyler stated.						29d. Date signed (Month, Day, Year)		
	VA			WV			1057285					
,	22		30. Name and address of person who	completed cause of death (Item		Print)	1			- 1112		
	8		G. Koilpillai	24 N. Walnut	12	H , 501 H	agerstown	MD.	217	40		
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	- 41)	*				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Corugra *ienkowek* Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death SALISBUM HICOMICO 10/10/ If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) last birthday) **Funeral** Min. Director 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 Yes 2 No ō 10g. Citizen of What Country? D items 23a 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after hite If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked or မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 2282 BAigg fe GREENHAC 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign dure of Funeral Service Licensee 22. Name and Address of Facility PEVANCEUILLE U4. 2.8 44h NEVAI 10481 LANGEM 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest phock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ast Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pt IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 N 2 🗌 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and litle of certifier 29d. Date signed (Month. Day, Year) 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 100 C. CA11011 M.O. 31. Date filed (Mo Registrar's Signatı State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ February Dorothy Bellis 2010 8:30 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico Lutheran Village at Harbor Point If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 M 2 X F Days Director 577-42-6031 91 05 08 1918 Massachusetts Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 21801 Tressler Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 🗶 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered nurse health care Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) မ Walter McIlhatten Gertrude Patrican 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Edwin Bellis Jr|son 7709 Upper Millstone Lane, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Durial 2 🔀 Cremation 3 D Removal from State 2 | 5 | 10 Salisbury Crematory 4 Donation 5 Other (Specify) Salisbury, MD 22 Name and Address of Facility Holloway Funeral Home Professional Association Signature of Funeral Service Lice Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PULMONARY disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dysp hasi A 24a. Was an autopsy perform certificate Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MD 2010 D36576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. DALISBURY TT RIVERSIDE DIE

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 24a per dr.,g901,03/11/2010dhb

Reg. No. 1 - State Registrar Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:15 A M February 6, 2010 William Cizler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Clinton Prince George's 6310 Woodley Rd. If Under 1 Year | If Under 24 Hrs. 8, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 1 X M 2 □ F Yrs 229-14-1439 92 March 4, Director 1917 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, Ite Medical Eventher must be hulling at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 6310 Woodley Rd. U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ N.1936-39 If Yes, Give Year or Dates: 1946-47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🎇 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber/Steamfitter Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John V. Cizler ဂ္ Johanna Biaha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6310 Woodley Rd. Clinton, MD 20735 Dorothy Cizler (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February permit. Pages Department of important: If it any Injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery16, 2010 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. M01555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnent at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnency in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 2**X** No 1 ☐ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an After this certificate has funeral director, page 2: autopsy performed? spital or Attending Physician: The hours after death. Inneral Director: After this certificate y filled in by the funeral director, par 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No Hospital: Other: 4 Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature FEB 12

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Garnette Elizabeth Childs Jan 31, 2010 9:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2604 Catskill Street Temple Hills Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🖵 F Director 577 24 9087 89 Feb 29, 1920 Washington DC Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must on motify of a 1 □Yes 2 No Directo Maryland | Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 2604 Catskill Street 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∰ No If Yes, GiveA Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □ XX Baltimore, Maryland 21215-0036 ģ Specify: 3 ₩Widowed 4 □ Divorced Specify: white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Finger Print Searcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Hicks Effa Deford မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Beverly Bauer (Niece) 3120 North Three Bs & K Road, Sunbury, Oh 43074 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State <u>-</u> 5 ₩₩Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Cedar Hill Cemetery Feb 11,2010 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death mediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

erral Director: After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burish-transit Hypercholesterolenia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 XXNo 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D23826 Reseconbe 7-1-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn Edgecombe, MD. 7700 Old Branch Ave, B201, Clinton, Md 20735

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 1 2 2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elizabeth Ciszek 3:40 February 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Hours Min. May 27, 1919 Pennsylvania Director 207-30-8509 90 Usual Residence of Decedent show 3a or 28a-f shov be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Y Yes 2 □ No Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Post Office Box 105 21782 Examiner must U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force . 0 Black. White, etc 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", 3 ¥ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Gaydos Eva Humanev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Kapinos / Daughter 84 Pinewood Hills Longmeadow, Massachusetts 01106 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Important; If any injury or St. Charles Cemetery 02/16/2010 Twin Rocks, PA . Signature of Funeral Service Lice 22. Name and Address of Facility Bast-Stauffer Funeral Home, 7606 Old National Pike Boonsboro, MD ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ise of each line. 23a. Part 1 Enter the disease, or complicate shock, or heart failure. List only one Immediate Cause (Final HEMISPHERIC ISCHEWIA Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjur) sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 G 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate performed 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2. No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be after death Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 20a Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MOHAMMED D66892

SH-9

DHMH 17 Rev 7/2009

Registrar

Mohammed Aziz, MD 251 East Antietam Street Suite 8057 Hagerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 16

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 22 per DVR G901 3/2/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1804 CAMPER GREGERY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 54/156UZY 11com 100 Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 ₹ M 2 □ F (Month, Day, Year -90-1829 43 Months Days Hours Min. Country) Director MARL Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits cemico 1 Yes 2 No MAINTICO LANCE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 71856 ROUAL 22154 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NONE EEd 50 EC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည (OATT: CAMPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UN CAMPER -Apt 90) EUCEL 2702 REC ERICK Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Holloway Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) MARGIARO Signature of Fune al Servio U ense 501 Snow Hill Road, Salisbury MD 21804 Part 1. Enter the disease, or complications that caused in shock, or heart failure. List only one cause on each live. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MULTISSSTEM ORGAN FAILORE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events LaminoMA Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit HIV resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2**X** No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes 7 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1469685 2/7/10 30 Many 5 14 Mares Aphy 17 At competed cause of death (Item 23a) (Type, Print) DRIVE SALISBURY Registrar's Signature State

Registrar

Physic /Med		Registrar			00,		Death		Reg. No.		1171	, 75
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State St				resulting in death)		101010	393.3
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Due to (or as a consequence of): d		uted d ansit	mi	cause. Chesase of four.			
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	0	death e atter d for u	iclar	in the past 12 months? 1			
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ָהָ מ	signed	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	֡֝֞֝֞֝֞֝֞֝֝֞֝֞֝֝֓֓֓֞֝֞֝֟֝֓֓֓֓֓֓֞֝֟֝֓֓֓֓֓֓֓֓	he lav te has age 2	duic			- autopsy	prior to completion of cause of death?
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	<u> </u>	ian; I	0	25. Was case referred to medical	26. Place of De	1 □ Yes 2, X	No 1 Yes 2 No
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	5	hysic this ce al direc	၉	1 ☐ Yes 2 No Hospital; 1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 ☐ DOA Other: 4 ☐ Nursing	h d	e 6 ☐ Other (Specify)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		ding for	Ei Ei		/ Work?	28d. Describe how i	njury occurred
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		Atten r deat ector: by the	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm.		28f. Location (Stree	t and Number or Rural Route Number.
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	5	rs after salter all Dir	Cert	4 Homicide building, etc. (Specify)		City or Town, S	tate)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		Funer Funer Ferrer	ca	Medical Examinery On the basis of examination and/or	ath occurred at the time, date and pla- investigation, in my opinion, death occ	ce, and due to the caus	se(s) and manner as stated. and place, and due to the cause(s)
30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature		vithin 2 the comple	Med Med	and manner stated.			
State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature 32. Degistrar's Signature)	21- 0			D005683	26	6
State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Al	1 1		30. Name and ordress of person who completed cause of death (Item 23a) (Typ	e, Print)	100	
	U†	-	9	31. Date filed (Month, Day, Year) 32. Bedistrar's Signature	D I Saint Pack	12/1001	Roomspara WO SING
			9		back		

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			For State	State of Marylan	-			Mental Hy	giene	
			Registrar		Cer	tificate of L	Death		Reg. No. 2	0.05477
П	Physicia	ın/	1. Decedent's Name (First, Middle, Last	-		Ashiell		2. Date of De Month	Day Van	3. Time of Death
	Medio Examir		MAY2911ER: +E 4a. Facility Name (if not institution, give:	Street and number)		1	Location of Deat	JAN	31 201 4c. County of D	0 1240 M
	LXamii	iCi	PENINSULA REGIO	64 4 0	TER.	0 /	sbury			eath MICO
	Funeral		5. Social Security Number 0 6. Se	X 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24/Hrs Hours Min.	8. Date of Bir	th 9.1	Birthplace (State or Foreign Country)
	Director		214 - 32 - 10 23 11 Usual Residence of Decedent	JM 2 XF 78	Yrs.	,		12-2	9-1931	MARYHAND
	show dat	tor	10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	Mary 28a-1 otifie	irec	MARYLAND Wicomin	o SA	lispi					1 ✓ Yes 2 □ No
	th the 3a or t be n	alD	10e. Street and Number 724 Madison	ct -		10f. Zip Code			10g. Citizen of What	
	ems 2	Funeral Director	724 Madison	12. Was Decedent Ever in U.S	. 13. V	Vas Decedent of Hi		pecify Yes or No-	14 Page - A	merican Indian,
9	ter de , or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	ŀ	Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black, W	hite, etc.
9	rurs af tural" al Exa	ted	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		☐ Yes 2 No	Specify:		Specify: B	lack
5	72 ho n "na Aedic	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give I	lent's Usual Occupa kind of work done of O NOT use retired)	ation luring most of wo	rking	16b. Kind of Busine	ss Industry
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+)		mestic			NONE	
pu	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "hatural", or items 2a be notified at rammetic event, the Medical Examiner	To Be	17. Father's Name (First, Middle, Last)	`			18. Mother's Nar	ne (First, Middle,	Maiden Surname)	_
yla	uld be I Meni narke natic	ř	Othe Dashiel				Maggie		CUN	
Maryland 21215-0036	2 sho th and 27 is r traun		19a. Informant's Name/Relationship (Typ	2 17	19b. Mailin	0 -	and Number or Ru	~ C	r, City or Town, State,	/
ē	1 and if Heal item 2		20a. Method of Disposition	20b. Pl	ace of Dispo	Scall, S.	HIE BIND	Date SALIC	20c. Location - City	or Town, State
<u><u>E</u></u>	Page 1 nent of ant: If it		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		emetery, cren	cizes PA		6-2010	Saliabo	vac. mol
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euneral Service Locuse			Name and Addres	ss of Facility		10.	1
	⊕ B = 8 0	117	23a. Part 1. Enter the disease, or comp	Voute		ELL'AR tu	in. Home	821 WE		His MH 21801
ı,	Physician/		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.			g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a Due to (or as a conseque		62000				-
	Examiner	Ļ.	Sequentially list conditions,	b. ————————————————————————————————————						
_	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
	xecute a and	Exa	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
09	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	L.	d						İ
926	rtificat ing ph e as th	/Mec	IF FEMALE:			-				
XC	ath ce attend for use	cian/	in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 [Ectopic pregnance	у		23d. Date of o	delivery Day Year
P.O. Box 68	the dealing the stranger	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown	salii J L					
9. O	r requires that the death certific been signed by the attending should be detached for use as	by P	Part II. Other significant conditions cor	ntributing to death but not resu	Iting in the ur	nderlying cause give	en in Part I.		_	to the cause of death?
ds,	equires en siç ould b	ted						1 🗆 '	Yes 2.0 3 √ No 3 □	Probably 4 \(\sum \) Unknown
õ	has be	Completed						24a. Was a autop	osy prior t	autopsy findings available completion of cause of
Ĕ	sician: The la certificate ha lrector, page 2		25. Was case referred to medical					1 🗆 Yes	rmed? death' 2 No 1 □ Y	es 2 □ No
<u>Vita</u>	ysicia s certi directe	To Be	examiner?	ospital: 1 ☐ Inpatient 2 😿	R/Outpatien		r:		lence 6 Other (Sp	
ō	ng Ph ter thi		27. Manner of Death 1		28b. Time of injury	28c. Injury	at		ow injury occurred	вспу)
ion	tendii Jeath. tor: Ai the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1□'	Yes 2 No			
Division of Vital Records,	l or Ai after Direc	Se	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physic	cian: To the best of my knowle	dge, death o	ccured at the time,	date and place, a	nd due to the cau	use(s) and manner as s	stated.
	the Hi hin 24 the Fu nplete		only one) 3 Li Certifying Nurse	er: On the basis of examination Practioner: To the best of my	knowledge, d	eath occurred at the	time, date and pla	ice, and due to the	nd place, and due to the cause(s) and manner	e cause(s) and manner stated. as stated.
			29b. Signature and title of cortifier			29c. License	number		29d. Date signed (Mor	nth, Day, Year)
	y gu		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Pr	int)	1)047/		4///	
	In		Chiis snyder	100 6. CAIRL	1 501	54	usbury	MO		
	Stat Registra	_	S1. Date filed (Month, Day, Year) FEB 09 20	mpleted cause of death (Item 2 100	D. 4	ale				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

	_		1 - For State Registrar	State of Ma	iryiand		tificate of I		•	gienę Reg. No		05478
	Physic		1. Decedent's Name (First, Middle, Las GERALD W.	t) EVANS	3				2. Date of De Month FEB	ath Day		3. Time of Death
,	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Dea			2010 County of Death	12:34 A ^M
-			ATLANTIC GENERAL	HOSPITAL			BERLI	N			WORCESTE	R
	Funeral		5. Social Security Number 6. Social Security Number 1	x 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	ay, Year)		lace (State or Foreign
	Director		Usual Residence of Decedent		69	Yrs.			MAR. 25	, 19		ÁWARE
	yland		10a. State 10b. County		10c. City, T	own or Lo	cation				10	Od. Inside City Limits
	a-fsl	ctor	DELAWARE SUSSEX		SEI	BYVI	LLE					1∭Yes 2□No
	or 28	Director	10e. Street and Number				10f. Zip Code	 _		10g. Citi	zen of What Coun	try?
	ath w	<u>a</u>	300 BAKER ROAD				19975				USA	
	er de items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No rto Rican, etc.)		14. Race - Americ Black, White, e	
21215-0036	illed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medien Examinar must be notified at	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 🛣 N If Yes, Give Year or Dates:	0	1	□Yes 2፟MNo	Specify:			Specify: WHI	
2-0	72 hou	Completed	15. Decedent's Edi	ucation	1	6a. Deced	ent's Usual Occupa	ation		16b. Kir	MILL nd of Business/Ind	
21	ithin 7 ne. ian "r	nple	(Specify only highest grade Elementary/Secondary (0-12)	le completed) College (1-4or 5-	-)	(Give I life. E	kind of work done o O NOT use retired	uring most of wo)	orking			•
2	led wi hygier her th	S	12				FARMER				RICULTUR	E
Maryland	l be fi ntal F ed ot	Be	17. Father's Name (First, Middle, Last)	T757.A	37.0				me (First, Middle,	Maiden	Surname)	
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Z Z	nd 2 s alth ar 27 Is r trau		PATSY H. EVANS/WI				g Address <i>(Street a</i>					Code)
ē,	item item othe		20a. Method of Disposition		20b. Place	e of Dispos	AKER ROAL ition (Name of atory or other place	SELBY	Date D		9975 cation - City or Tov	wn, State
Ē	Page nent c unt: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			_	CEMETERY	2/13	8/10	CEIL	2VVIII E	DELAMADE
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be notified anone.		21. Signature of Funeral Service Licens	ее	T T T T T T T T T T T T T T T T T T T		Name and Addres		5/10	25111	OI VILLE	DELAWARE
	20 = 20		_ W. By East		2134						ILLE, DE	LAWARE 1997
			23a. Part 1. Enter Inf. disease, or comushock, or heart failure. List only o	flons that caused to cause on each line	he death. [Do not ente	r the mode of dying	g, such as cardia	c or respiratory a	rest,		Approximate Interval Between
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	15CV	12						40	Onset and Death
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	t the c by the achec	hysi	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown		. 30	Other (specify)					
ک	fung Physician: The law requires that the di After this certificate has been signed by the funeral director, page 2 should be detached	by P	Part II. Other significant conditions con	ntributing to death but	not resulting	g in the und	derlying cause give	n in Part I.	23e. Did to	bacco us	se contribute to the	e cause of death?
Sord	equire sen si ould b	ed	PREYICUS BY-PA	55, CHF,	<u> 6017.</u>	7)			1 🗆 Y	es 2[] No 3 ☐ Proba	bly 4 Unknown
Š	law r las be	Completed							24a. Was a		24b. Were autop	sy findings available
ב ה	cate by	Sol							autop perfor 1 □ Yes		death? 1 □Yes 2	pletion of cause of
VITAL	rcian certifi ector,	Be	25. Was case referred to medical examiner?	12-1	-				ath (Check only or			
5 8	Phys this aldir	۲.	1 Yes 2 No	lospital: 1 Inpatien				4 LI Nursing F			☐Other (Specify)	
5	ding th. After fune	tion	1 ▶ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year)	o. Time of Injury	28c. Injury Work? M 1 🗆 Y		28d. Describe h	ow injury	occurred	
2	Atten r deat sctor: by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	/ - At home,	farm, stree	1	es 2□No	28f Location /S	treet and	Number or Rural	Pouto Number
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		Medical (29a. Certifier 1 ☐ Certifying Physical Check only one) 1 ☐ Certifying Physical Exami	sician: To the best of ner: On the basis of e	xamination	lge, death and/or inve	occurred at the timestigation, in my op	e, date and plac	e, and due to the durred at the time, o	ause(s)	and manner as sta	ated.
1	ithin (Mec	29b. Signature and title of certifier	and manner state	ed		29c. License					
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,	19x1	-	30. Name and address of person who ca	mpleted cause of the	th (Item 22	(Type P	int)	Des 24-1		02-	- 69-10	
	U		DOROTHY P. A.	Lywort	M.	D.		MON ST.	Sum	1 18.11	, Mo. 2	151.3
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	E CALLA LANGE		_									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JEAN MATILDA FAGAN a^{M} 3:19 FEBRUARY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chester River Hospital Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 6 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 12 F 221-14-2537 85 **Director** Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Ves 2 No MD Kent Betterton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Main St. 21610 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, Ite Medical Examinary once. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner - Operator 10 Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George William Shellworth Johnson Rebecca Wrightlev ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Larrimore P.O. Box 196 Betterton, MD. 21610 (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Galena Cemetery 2/26/10 4 ☐ Donation - 5 ☐ Other (Specify) Galena, MD. 21. Signature of Funeral Service No 22. Name and Address of Facility Galena Funeral Home of Stephen L. Sc 118 West Cross St. Galena, MD. 21635 4 M00510 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cordiac arrest pulseless electrical disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cornan Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-tran emb whe and Due to (of as a consequence of): P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 🛣 No Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform polonged Division of Vital 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar

completely

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Saleem , MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed M. Saleem, M.D.

Dr

29c. License number

D62773

100 Brown St. Chestertown, MD. 21620

29d. Date signed (Month, Day, Year)

2/21/20/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

2010 0548

Mervyn William Frazier State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** Month Day February 17, 2010 1558 hrs Mervyn William Frazier 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 100 Greenway # 324 Perryville Cecil 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Director Months Davs Hours Min 1 X M 2 F 216-48-0512 63 11/24/1946 England Usual Residence of Deceden D 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 No I. Pages 1 and 2 should be filed within 72 hours after-death with the Maryland ment of Fleath and Mental Hygiene and attural?, or items 23s and 28s-f sho or other than "natural.", or items 23s ar 28s-f sho or other than matural. Maryland Cecil Perryville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Greenway, Apartment 324 21903 Uni<u>ted States</u> Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 1 X Yes 2 Yes, Give Year 1966-1968 3 Widowed 4 X Divorced 1 Yes 2 No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mobile Home Baltimore, MD 21215-0036 12 Supervisor Manufacturing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Andrew Frazier Winifred Rosemary Haggett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Guinn/Daughter 109 Roberts Way, North East, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Conowingo Baptist February 22, 2010 Donation 5 Other Specify Cemetery Conowingo, MD 22 Name and Address of Facility Hicks Home for Funerals, nature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD**Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death raminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED ned by the attending physician detached for use as the burial -AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month past 12 months 2 Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 ✔ No 1 Yes 2 No the Hospital or Attending Physician: Tr hin 24 hours after death. the Funeral Director: After this certifica pyletely filled in by the funeral director, pa 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 V Natural Pending 1 Yes 2 No 2 Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc 3 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined 4 (Specify, Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 18, 2010 e 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

X

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Fife 2010 9:37 PM Margaret February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4850 Bicknell Road Charles Marbury Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
June 17,1931 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 □ F Months Hours 342-34-0012 78 Yrs England **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f shov the Wedical Evartiner rust be notified at 1 ☐ Yes 2X No Completed by Funeral Director Lanier GA Lakeland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with USA 31635 19 Hart Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Ye ar or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be th and Mental F 7 is marked ot traumatic ever Pages 1 and 2 should be Christopher Millard Gillian Millard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Petitjean Daughter Health if Helen 8441 Vickers Road, Hahira, GA 31632 other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition jo __ 1 ☐ Burial 2 Tremation 3 ☐ Removal from State ō Department of important: If any injury or once. Brinsfield-Echols Crem. 2/10/2010 Charlotte Hall,MD 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee AREHARI CECHOLS' FUNERAL HOME, P.A. M01458 211 St. Mary's Ave. La Plata,MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** C /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 🗌 No 3 Probably 4 Unknown icate has been significate page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ONO 25. Was case referred to medical Be 26. Place of Death (Check only one) Sister examiner? In laws Hospital: Other: 24 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) Certification: To 28a. Date of Injury 27. Manper of Death 28b. Time of 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Baltimore, Maryland 21215-0036

28c. Injury at Work? (Month, Day, Year) 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28W 6

and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0tc MD 20646

State Registrar

Medical

31. Date filed (Month, Year) EB 2 2010 1

32. Registrar's Signature ENERIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Bepartment of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Edwin Benjamin Freeman February 1, 2010 5:35 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Futurecare Pineview Clinton Prince George If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 □ F 579-18-3714 May 16, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5391 Emma Lane 20640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 🏋 Married 1 ☐ Yes 2 XNo WWII Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Firefighter U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin George Freeman Anna Elizabeth Burgess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lolita Marlene Sullivan Daughter 5391 Emma Lane, Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service 2010 Alexandria, Virginia 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -una Cancer disease or condition resulting in death) Due to (or as Consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstractive D ulminary 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ANo 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Examiner requires that the death certificate be executed Records, or Vital Division Attending ō To the Hospital o within 24 hours aft To the Funeral Di

Physician

/Medical

Examiner

Funeral

Director

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Examiner

Physician/Medical

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Certification: To

Medical

State

29b. Signature and

31. Date filed (Month,

title of certifie

, Day, Year) FEB 1

Bahram Pishdad, M.D.

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

ACY.

1 and 2 should be
1 Health and M

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001 29c. License number

1328 Southern Ave., SE, Washington D.C. 20032

D 51520

29d. Date signed (Month, Day, Year)

2-7-10

and manner stated.

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 05483 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death February 10, 2010 **Physician** Mildred Ley Griffin 3:15 A M /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick 8. Date of Birth (Month, Day, Yea 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 172-50-4844 1□ M 2**X**F Days 102 Director July 15, 1907 Pennsylvania Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits ıral", or Items 23a or 28a-f shov I Exaπiner must be notifled at Frederick Frederick Director Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 7407 Willow Road United States death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 X No White Completed by Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Executive Security** Oil Production Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ferdinand Ley Amelia Henschel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau Kathy Moloney / Daughter 130 East Third Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 13, 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 2010 21. Signature of Funeral Service License 22. Name and Address of Facility **Keeney & Basford P.A. Funeral Home** M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** da 06 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence of Examine law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2☐4o Month Day Year 5 ☐ Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe or Vital Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 16 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

30. Name and address of person who comp

FEB 25 2010

DHMH 17 Rev 1/2001

Dic

MI

cause of death (Item 23a) (Type, Print)

29c. License number

D16428

29d. Date signed (Month, Day, Year)

300 West Ninth Street, Frederick, Maryland 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Grace Wiser Grove February 21, 2010 3:56P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Assisted Lvg Nursing and Rehab Ctr. Prince George's Adelphi Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign 8. Date of Birth Months Days Hours Min 577-28-1005 MaryTand JaM°.10°.4924 Director 86 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the M-dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 280.6 ct....ann injury or other traumatic event, the Medical Experiment 2000.6. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 Tes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 11615 35th Place 20705 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White Specify. 3 Divorced 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Construction Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Floyd Wiser Alice Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11615 35th Place Beltsville, Maryland 20705 Harry R. Grove -husband 20a. Method of Disposition
1 ☐ Burlal 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Metropolitan Crematory 2/25/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licen Bonaid ViesBórgWardt Funeral Home, PA ald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by. s been signal based to should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of sate has b page 2 s autopsy After this certificate funeral director, page performe death? 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director, of completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) fistrar's Signature FEB 25 2010

30. Name and address of person who completed cause of death (Item 23a/Type, Print)

Njdecka Udochi, M.D. 9055 Chevrolet Drive,#100 Ellicott City, Maryland 21042

29c. License number

February 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month Feb 6, Lewis Guido, Jr. 2010 5:41 Α 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 27380 Dewey Place Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ₽ M 2 □ F 73 220 32 7239 July 5. 1936 Washington DC Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □No Maryland St. Mary's Mechanics ville 10e. Street and Number 10g. Citizen of What Country? 27380 Dewey Place 20659 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2 □ No If Hes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Korean 1 ☐ Yes 21 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis Guido, Sr. Ellen Dettmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Guido (Wife) 27380 Dewey Place, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 2/12/2010 Waldorf, Maryland Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, mediate Cause (Final disease or condition resulting in death) Metastatic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, nours after death.

neral Director: Af 24 hours a

Physician

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f show

"natural",

permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Modifical once.

Physician

/Medical

Examiner

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cate has been signed by the page 2 should be detached

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Physician/Medical

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Completed

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Certification: To

Medical

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

Part II. Other signit	icant conditions of	ontributing to death but not res	ulting in the underlying o	ause given in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknown		
					24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No		
25. Was case refer	red to medical			26. Place of De	eath (Check only one)			
examiner? 1☐ Yes 2∰	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DO	Home 5 Residence 6	me 5 Residence 6 Other (Specify)			
27, Manner of Deat 1 Matural 2 ☐ Accident	h 5 □ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif		, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,		
29a. Certifier (Check only one)	1 Certifyi ng Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina	owledge, death occurred ation and/or investigation	at the time, date and pla- , in my opinion, death occ	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)		

29c. License number

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NRV

00068120

California.

29d. Date signed (Month, Day, Year)

mD

2010

20619

Shah

mo 23415 Three Notch Road

Registrar's Signature

31. Date filed (Month, Day, Year) FEB 1 2 2010

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year EDWARD DEFRECE GROUT 5,30 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coffman Nursing Home Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 102 M 2 □ F Florida 95 Yrs. 265-05-7475 Director 07-06-1914 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other then "naturel", or Items 23a or 28a-f show other treumatic event, Inc Madical Examinar must be notified at Maryland Washington Hagerstown 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 20014 Rose Bank Way Apt 323 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 → Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1942 Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No 3 Widowed 4 Divorced 1944 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 11 public relations recreation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fit and Mental H Adelbert B. Grout Laura Blethan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 le Bettiejean Grout - wife 20014 Rose Bank Way Apt. 323, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot February 15, 2010 Hagerstown, Maryland 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hagerstown Crematory ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Minnich Funeral Home 22. Name and Address of Facility (Kalen Ole 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician INFARETTON MYOCARDIAL disease or condition resulting in death) 15-20 mm /Medical Due to (or as a consequence of): Examiner CORANAMY DISEMIE MUETH Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed AD U ANCED DEMENTIA burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician ned for use as the buria Physician/Medical as the esn. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death P.O. 5 Other (specify) 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 🗗 No 2 🔊 No 1 🗌 Yes 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 📉 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 🖄 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 MO 15. 2010 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-1+1 1190 HAGERS TOWN 31. Date filed (Month) GITA ZAUN OMS AGN A 32. Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b, per Fh G901 3/11/10 TT

For State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Mae Hettie Hay S 631PM /Medical February 3010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Calvert Memorial Hospital Frederick Calvet 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1□ M 2√X Months Days Hours 578 34 0791 80 Director 5, 1929 Virginia April Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2□No Director Prince George Maryland Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 8505 James Street 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 ☐ Yes 2 ☐ No Specify: þ 3√ Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Handicap Aid Transporation School 42 should be filed w h and Mental Hygier 7 is marked other th 12 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Adam Rembowski Ada Elizabeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Linda Williams (Daughter) 7118 Lakeshore Drive, North Beach, MD 20714 Pate 2010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signatine of Funeral Service Light MOIS Alexandria Ferry Road, Clinton, MD 23a. Pa.1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipt, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trai Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death Day Year 5 Other (specify) the detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy perform certificate 1∐ Yes 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 📉 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 npatient Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation (Month, Day Year) Injury 2 Accident 1 ☐ Yes 2 ☐ No after death completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) DC7594 2010

death.

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Hospital

Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

Cheryl

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Hospital Ruad

Prince Frederick, MD

MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

32. Registrar's Signature

MID

Hepp.

FEB 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ Hollace Μ. Harris Month 0750 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAUSBUR Mamic. 10 If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 474-56-6819 Days Director Yrs. 0411011948 Minnesota Usual Residence of Decedent shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Wicomico Delmar 1 🛱 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 30517 Danwood Drive 21875 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: "natural" 3 Divorced 4 Divorced Specify: white other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) office manager dental office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Karl Nelson Arleen (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30517 Danwood Dr., Delmar, MD 21875 Jeffrey Harris spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 2 | 12 | 10 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association Signature of Funeral Service Lice Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ASCUD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lusease or impury Examine Due to (or as a consequence of): use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year g Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed l irector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by multiple myelona 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perforn death? 1 ☐ Yes 2 No Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 XER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending death. within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 1 Tes 2 \square No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar only one)

3 Certifying

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FEB 09 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E.

. Registrar's Signa

29c. License number

1+50497

CARROLL St. Salisbury md.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment o		and Mental	Hygien Reg. N		1 151.80
	Physicia Medic		Decedent's Name (First, Middle, Las MARY KATHERI	NE ISENE	BERG				of Death		3. Time of Death 15:50P M
	Examir	ner	4a. Facility Name (if not institution, give ST. MARY S HOS 5. Social Security Number 6. Se	PITAL	e (In yrs. last birthday)		n, or Location on NARDT(NWC	S'	c. County of Dea	'S
	Funeral Director	r		M 2 F	65 Yrs.	Months Da	ays Hours		of Birth th, Day, Year) 18-19	9. BII	thplace (State or Foreign buntry)
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD. ST.MAI 10e. Street and Number 26960 COX DRIV		MECH	IANICS		.,,-0,		itizen of What C	1 ☐ Yes 2 🕱 No ountry?
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121215-0036	d within 72 ho lygiene. ther than "nat the Medica	Be Completed by	15. Decedent's E. (Specify only highest gra		(Give life, Di	dent's Usual Od kind of work do O NOT use reti	one during most red) KER		OW	Kind of Business	,
Maryland	ould be file d Mental H marked of matic ever	ToB	17. Father's Name (First, Middle, Last) JOHN LLOYD KO 19a. Informant's Name/Relationship (Ty		1		MAR	er's Name (First, M Y ELIZA	BETH	RACEY	
	Page 1 and 2 shoul ment of Health and ant: If item 27 is m ury or other traum:		BARBARA KITCHI 20a. Method of Disposition 1	ENS-DAUG	HTER 2169 20b. Place of Disponsemetery, crem	0 CHA	NCELLO f place)	RS RUN Date	RD .	GREAT Location - City or	MILLS, MD. Town, S2t0 634
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (Specification of Suneral Service Licens	M0047		. Name and Ad	ddress of Facilit	ERAL SE	RVICE		WN, MD,
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. Box 6876	ath certific attending p for use as	/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3 E	Ectopic pregi Other (specify				23d. Date of de Month	livery Day Year
ds, P.O.	requires that the des been signed by the s should be detached t		Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying caus	e given in Part I		Did tobacco		the cause of death?
Division of Vital Records,	sician: The law requi certificate has been rector, page 2 shoult	Completed by						1	Was an autopsy performed? Yes 2 XN	prior to	topsy findings available completion of cause of
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on of \	Or the Hospital or Attending Physician: within 24 hours after death or the Funeral Director: After this certific completed filled in by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injui (Month, Day	ry 28b. Time of	28c. I	njury at work?		ribe how injui		ury)
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	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical Exami)	er: On the Lasis of ex	my knowledge, death o xamination and/or invest	igation, in my o	pinion, death oc	curred at the time.	date and place	e, and due to the	cause(s) and manner stated.
•	1 w W		1 Dilla		and the control	<u> Do</u>	ense number 0617 (21	ite signed (Monti	10
	Stat		30. Name and address of person who compared to the compared to	ay Bbo	eath (Item 23a) (Type, P	int)	hah As	sociates	Holl	yweod r	nd 20636
	Registra		31. Date filed (Month, Day, Year) FEB 25 20	10 Janen	N B. A.	File					

DIC.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G901 3/03/2010 JH State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death u 11 2010 Physician/ Month D John Wilbur Ingram, Jr. Medical a. Facility Name (if not institution, give street and number) c. County of Death **Examiner** 4b. City, Town, or Location of Death Washington County Washington County Hospital Hagerstown Social Security Number 6. Sex 1 ⚠ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Jan. 25, 1926 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Days 220-18-3380 Hours Min. MaryTand 84 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10b, County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19537 Lorraine Terrace 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?

1 A Yes 2 9 197. –
If Yes, Give 1 946 Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) or other traumatic event, the Aeronautical Engineer Aircraft IndustryCo. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wilbur Ingram Virginia French Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Ingram-son 3810 Ridgelea Dr. Fairfax, VA 22031 20a. Method of Disposition
1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Smithsburg Crematory 2-13-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern BLvd. North Hagerstown, MD 21742 21. Signature of Funeral Service Licensee Kaitl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 60 Cunter-100 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and-trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death use 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death the Unknown 9 Unknown Division of Vital Records, P.O. ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician. me, within 24 hours after death.

To the Funeral Director After this certificate I completed filled in by the funeral director, page performed? Yes 2 No 1 Tes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🗗 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, Mucha 041667 Milon

Registrar
DHMH 17 Rev 7/2009

State

Nedicil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day Year) FEB 16

Mclor Meale

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jessie Cassandre Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMRMC-WM Health System Cumberland **Allegany** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TX F Months Days Hours Min. (Month, Day, Year) (1ay 3, 1950 Director 233-78-4679 Yrs. May Cumberland, MD Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits WV Mineral 1 X Yes 2 No Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 Maple Avenue 26726 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Machine Operator Paper Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of realth and Manta Important: If it m 27 is marked any injury or o her traumatic ev ၉ James Robert Phillips Mary Madeline Rowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s ealth Lynn M. Phillips/Daughter 4109 Southern Ave., Apt. 204 Capitol Heights, MD 20a, Method of Disposition Page 1 a 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20743 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 20 Feb. 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory 2010 Cumberland, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Smith Funeral Home 35 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 00 Medical Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Year Day s been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 000 0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an neral Director: After this certificate has filled in by the funeral director, page 2 autopsy nemo 1 Yes 2 No Yes 2 L/N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital ပ 1 🗌 Yes 2 No Other: after death. Director: After this 1 Dupatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending Accident 1 Yes Investigation 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fund completed 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Blanche Mavromatis,

31. Date filed (Month,

FEB 25 2010

DHMH 17 Rev 7/2009

DIL

904 Seton Drive

Cumberland, MD

M.D.

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MD 2 d 2 should lith and M n 27 is m.	S L	2	19a. Informant's Name/Relations Thomas A. Jone	, , , , , , ,	r							umber, City or Tow Maryland		
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Divisi tal or Atte	ed in by t	al Certificate:	3 U Suicide 6 U Could not be determined 28e. Place build Home	ing, etc. (Specify	ome, farm, stree	et, factory, office		City or Town	reet and Number or Ru , State) 3502 0 Lisbury, MD	1d Pocomoke
the Hospi in 24 hou the Funer	npleted fil	Med	29a. Certifier (Check only one) 1 Certifying Physician: To the base only one) 2 Medical Examiner: On the base only one) 3 Certifying Nurse Practioner:	sis of examination	n and/or investi	pation, in my opinion.	date and place, and	due to the caus	se(s) and manner as st	ated.
	COL		29b. Signature and the of certifier			29c. License r	number		9d. Date signed (Mont	h, Day, Year)
Ph	W		30. Name and address of person who completed cau		_				14110	
	State	. 3	Chris Synder Do. 10 31. Date filed (Month Day Year) EBUY 2010	0 E Car	ture.	Salis	my ms	218	301	
Re	gistra	r	FEB 09 2010 Z	egistrar's Signa	B. Spa	ww				

10-01082 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Matthew Kaplowitz State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month **Medical Examiner** 1355 hrs Matthew Aaron Kaplowitz February 6, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Frederick 999 West Patrick Street Frederick 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** ForeigWashington, Country) DC Director 218-02-1203 Months Days Hours 32 09/14/1977 1 X M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits (homeless) Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she ro other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White etc. 1 X Never Married 2 Married 1 Yes 2 X No If Yes, Give Year Yes 2 X No specify: White ₽ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Kaplowitz Constance Arlene Herridge 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Kaplowitz / Father 7056 Catalpa Road, Frederick, MD 21703 Baltimore, Permit. Pages 1 and Department of Healt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Feb. 19, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State portant; 2010 Frederick, Maryland Resthaven Crematory 4 Donation 5 Other Specify 21. S F era ervice Licenses 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Parl. Enter the discard, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician fallure. List only cause on each line /Medical Death a Oxycodone intoxication and cocaine use Immediate Cause Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a,27,28a-f,permE, g900 2/26/10 TT ed by the attending physician detached for use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnance 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown has been signed by t 2 should be detache 23e. Did tobacco use contribute to the cause of death? Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ Δ. Completed Records, 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene 1 🗸 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Division Natural Pending 1 Yes 2 No 2/6/2010 Fd 1:50 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be (Specify) hotel determined Homicide Frederick, MD

1 Yes 2 No Approximate Interval Between Onset and 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 28f. Location (Street and Number or Rural Route Number City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. February 7, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State anke ME TANK Registra OCME DHMH 17 Rev 1/2001 **ORIGINAL** OCMF 2006

			For 1_ State	State of Mar				Mental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle,	Last)		ertificate of	Death	Re 2. Date of Death	g. No. 2	3. Time of Death
Н	Physici /Media		Clyde Richard K	enda ll				February		12:00 P M
	Examir		4a. Facility Name (If not institution,				or Location of Death	1	4c. County of Death	
	Funeral		11739 Crystal F 5. Social Security Number	6. Sex 7. Age	(In yrs. last birthd	Smithsb ay) If Under 1 Year	0	8. Date of Birth	Washingtor	County place (State or Foreign
	Director		218-24-9299	1 X M 2□ F	86 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 29,	1923 Mary	qtry) -
yland	WO M		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or				1	10d. Inside City Limits
e Mar	Ba-f sh	ctor	Maryland Washing	ton County	Smithsbu	ırg				1 □ Yes 2 No
th with th	23a or 2	Funeral Director	10e. Street and Number 11739 Crystal F	alls Dr.		10f. Zip Code 21783			g. Citizen of What Cou J.S.A.	ntry?
d 21215-UU36 filed within 72 hours after death with the Maryland	giene. r than "natural", or items 23a or 28a-f show It is Madical Examinar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Event Armed Forces? 1132 Yes 2 \(\) No If Yes, Give Year or Dates:	ver in U.S. 1	3. Was Decedent of If Yes, specify Cub 1 □Yes 2 ※No		pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036 d within 72 hours aft	ene. than "natur is Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(G.	cedent's Usual Occu ive kind of work done e. DO NOT use retire hinist	pation during most of work d)	king	6b. Kind of Business/In	ŕ
	ent,	Be Co	17. Father's Name (First, Middle, La	ast)			18. Mother's Nam	ne (First, Middle, Ma		,•
ryland	nd Menta marked matic ev	70	Clyde Jacob Ken					oms Kenda		
Mar and 2 sh	alth an 27 is r er traur		19a. Informant's Name/Relationship Carolyn McCartne						city or Town, State, Zipsburg, MD 2	
Saltimore, bermit. Pages 1 ar	Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	20b. Place of Dis	position (Name of rematory or other plate Valley ((ce) 2-11	Date 010 20	oc. Location - City or To	own, State
Dail	Departi Importa any Inji once.		21. Signature of Funeral Service Lie	censee 7					Fiery Fune	
			23a. Part 1. Enter the disease, or et shock, or head failure. List or	omplications that caused th					ngerstown,	Approximate
	ysician		Immediate Cause (Final disease or condition	a. Con		Stery S				Interval Between Onset and Death
	ledical aminer		resulting in death)	Due to (or as a c						
D.	±.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a c	consequence of):					
, execute	and aftrans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c	consequence of):					
o / oU, icate be executed	physician and s the burial-transit	dical E		d						
X 00	ding pł se as tł	/Med	IF FEMALE:	200 16 170 0140 014						
the death cer	So the Function of the attending completely filled in by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	B ☐ Ectopic pregnand D Other (specify) _	:у		23d. Date of delive Month	ery Day Year
D, T	igned to	ρ	Part II. Other significant conditions		not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
requires t	been s	eted	Diaba	etes Thension						bably 4 🗌 Unknown
n: The lav	After this certificate has funeral director, page 2	Completed	<u>'</u>	Mension				24a. Was an autopsy performe	prior to co death?	psy findings available mpletion of cause of
yslcia	nis cert directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ent 3 DOA Oth		h <i>(Check only one)</i> ome 5 M Besiden	ce 6 ☐ Other (Specif	
ing a	After th	ion: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yo	(ear) 28b. Time	Wor	ry at k?	28d. Describe how		
l or Attence	Director:	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Injury	- At home, farm, s (Specify)		Yes 2 □No	28f. Location (Stree City or Town,	et and Number or Rura State)	l Route Number,
he Hospita in 24 hours	he Funeral	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of n aminer: On the basis of ex and manner stated	kamination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the cau red at the time, date	ise(s) and manner as s e and place, and due to	tated. the cause(s)
Tot	Som Com	Ž	29b. Signature and title of certifier	10 11		29c. Licens		29d	. Date signed (Month,	Day, Year)
7	D		30. Name and address of person wh	o completed cause of deat	th (Item 23a) (Tyro		8471		4/11/10	>
4	* 1		William B. Kern	ns, MD 22911	Jeffers	on Blvd.,	Hagersto	wn, MD	21740	
**	Stat Registra		31. Date filed (Month, Day, Year) FEB 1 6	2010 32. Fegistrar's	Signature	bare				

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 05496 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February Lawrence G. Lates 13, 2010 18:29 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Nov. 10, 1926 9. Birthplace (State or Foreign Country)
New York **Funeral** 1 ▼M 2 □ F Days Hours 111-18-2633 83 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location , or items 23a or 28a-f show an iliner must be notified at 10d. Inside City Limits Maryland Prince George's Greenbelt Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4A Hillside Drive 20770 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∆Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII event, the Medical Exam ò 1 ☐Yes 2 ➡No Specify: Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Procurement Analyst Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) Sarah Goldberg traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Ruth C. Lates -wife 4A Hillside Drive Greenbelt, Maryland 20770 20a. Method of Disposition
1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 2/18/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Daniel V150 23a. Part 1. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYD CARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dualte (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Completed HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No has page 2 s 24a Was an autopsy performed Ves 2 No certificate 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 🗌 Yes 2 No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JODQ16 D40324 FEBRUARY 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE, TAKOMA PARK, MARYLAND TERMY JODRIE, MO, FACEP 7600 CARROLL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hee Lee February 17, 2010 15:18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 □ M 2**V**□ F 213-96-1777 96 Now 122 2 1913 Korea Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 🗌 Yes 2 🖺 No 10e, Street and Number P 10f. Zip Code 10q. Citizen of What Country? er than "natural", or items 23a o the Medical Examiner must be Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a jury or other traumatic event, the Medical Examiner must b Funeral 20902 1135 University Blvd. West, #309 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian If Yes, Give Year or Dates 3X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chang Hyuk Lee See Peang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Sook J. Kim -daughter 3330 North Leisure World Blvd.,#127 Silver Spring,MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20c. Location - City or Town, State cometery, crematory or other place)
Metropolitan Crematory 2/22/2010 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or lingury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be 687 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year signed by the Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ XNo 2 X N Yes or Attending Physician: 25. Was case referred to medical of Vital l e 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2X No Other မြ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Certificat 5 Pending work? 1 ☐ Yes Division 2 🗆 No Investigation 6 Could not be Accident Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa**r**ur 29d. Date; signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 20 Î January 22:00P Arthur Lange 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. $\text{May 6, } ^{\text{(Month, Day}} 1926$ 83 215-36-5738 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No <u> Maryland|Prince Georges</u> Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10909 Crossroad Trail 20613 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates. Army 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince Georges Elementary/Seconday (0-12) College (1-4 or 5+) Maintenace Supervisor County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gustav Lange Wilhelmina Schalin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolly Lange/ Wife 10909 Crossroad Trail, Brandywine, MD. 20613 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) <u>Maryland Vet's Ceme. Feb. 8, 2010 Cheltenham, MD.</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home <u>3035 Old Washington Rd. Waldorf, MD.</u> 23a. Part 1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Due to (or as a consequence of): disease or condition Unknown resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consecuence of: that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year 2 🗌 No 9 Unknown

Physician/ Medical Examiner

Physician/

Medical

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permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event,

Baltimore, Maryland 21215-0036

Exami and -transit Hospital or Attending Physician: The law requires that the death certificate be executed burialphysician s the burial Completed by Physician/Medical attending p as been signed by the 2 should be detached Jas page certificate | within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Certificate: To

IF FEMALE:

Division of Vital Records, P.O. Box 68760

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art II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 1 □ Yes 2 □ No
5. Was case referred to medical examiner?	26. Place of Death (Check	only one)
1 ☐ Yes 2 🖾 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	ne 5 Residence 6 Other (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
9a. Certifier 1 Certifying Phys (Check 2 Medical Examir	ician: To the best of my knowledge, death occured at the time, date and place, and her. On the basis of examination and/or investigation, in my opinion, death occurred at	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) and manner stated.

within 2 To the (2+1) BBM 3

Medical

L MENDOZA

D0064153

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20735 8926 WOODYARD RO#201, CUNTON, MD

31. Date filed (Month, Day, Year)

29b. Signature and title of

egistrar's Signature

Registrar

10-01507

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

Kev	in Allen Merc		For State Ce	ertificate of	neath Death		. No.	0 00477
	Physicia		egistrar . Decedent's Name (First, Middle,Last)			Date of Death Month	Dav Year	3. Time of Death
-	çal Examir	ıer	Kevin Allen Mercer			February 19), 2010 4c. County of Deatl	1116 hrs
		4	a. Facility Name (if not institution, give street and number)	4t	 City, Town, or Location of Hagerstown 	Death	Washington	·
			50 Summitt Avenue Apt. 4425 Social Security Number 6, Sex 7, Age (In yrs.	. (ast birthday)	If Under 1 Year If Under	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	rthplace (State or +
	Funeral Director		. Social Security Number 219-17-5117 6. Sex 7. Age (In yrs.	Yrs.	Months Days Hours	Min. Aug. 1	1,1980 Foreign	nthplace (State or t gn DISFIICT puntr@olumbia
	ķ			ty, Town or Location	n			10d, Inside City Limits
	. A	- 1		encastle				1 Yes 2 No
	ryland a-f sh	황	0e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	intry?
	or 28	Director	9478 Fort Stouffer Rd.		17225		U.S.A.	
1	-death with the Maryland or items 23s or 28s-f show any must be notified at once.		1. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13 Was	Decedent of Hispanic Origins, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
0	death r iten	Funeral	1 Never Married 2 Married 1 Yes 2 No			,	Specify: Wh:	ite
)	after	3	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 No specify:	ind of work done	16b. Kind of Business	/Industry
	hours natur Exam	힣	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of working life. DO NOT u	ise retired)		
	36 nin 72 s. than	Be	12	Instal			Commercial	Glass Co.
	5-0036 iled within 72 Hygiene. 1 other than	Completed	17. Father's Name (First, Middle, Last)			Name (First, Middle, M		
	215 be file ntal H rked c	æ	David Kirk Mercer		Me La	anie Jane W	ennberg Me	ercer
	21 hould nd Me is ma		19a. Informant's Name/Relationship (Type, Print)	3	Fort Stouffer			
	MC 2 s alth aut 27 raum3	- 1	David K. Mercer-father 20a Method of Disposition 201	b. Place of Disposi	tion (Name of cemetery,	Date Date	20c. Location - City of	r Town, State
	Ore,	-1	1 Burial 2 X Cremation 3 Removal from State	crematory or oth	erplace) Crematory	2-22-2010	Smithsburg	. Maryland
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	- /4	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ame and Address of Facility			
	Bal permi Depar Impo injur	11	Douglas A. Fierv per DVR	133	1 Eastern BL	vd. North H	agerstown,	MD 21742
	Physician		23a. Part I. Enter the disease, or complications that caused the deafailure. List only one cause on each line.	ath. Do not enter th	ne mode of dying, such as ca	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
	/Medical	- 1		Heroin) J	ntoxication			Death
	Examiner		or condition resulting in death) Due to (or as a consequence	e of):				
		<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	e of):				
		Examiner	cause. Enter Underlying Cause	- of):				
	led Insit	Exa	events resulting in death) Last Due to (or as a consequence d.	e or).				
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical	■ UNPENDED □ AMENDED 23a,27		er me g901 3	-25-10 vt	23d. Date of delive	20/
	760 ficate g phys s the b	an/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the 23c. If yes, outcome of pregnant in the		tal death 3 Ectopic	pregnancy	Month Month	Day Year
	x 68 h certi tendin	ਹ	past 12 months?	of death 5 Ot	her (Specify)			
	Box 6876(ne death certificate the attending phy hed for use as the b	Physi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but no	ot resulting in the	inderlying cause given in Pa	nt I. 23e. Did to	bacco use contribute	to the cause of death?
	tal Records, P.O. cian: The law requires that the certificate has been signed by ector, page 2 should be detach	by F	Part II. Other significant conditions continuing to death but in	or resulting at the	and only and	1 Yes	2 No 3 P	obably 4 Unknown
	duires en sig	Completed				24a. Was autop		autopsy findings available o completion of cause of
	Sorc law re has be	ם		-			rmed? death	?
	Re(The ficate		25 Was case referred to medical		26.Place of Death			
	'ital sician is cert lirecto	a	examiner? Hospital: 1 Inpatient 2	ER/Outpatien	DOA Other	Nursing Home 5	Residence 6 🗸 Ott	ner: Scene
	n of Vit ding Physic h. : After this	٤	1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of			how injury occurred	
	On cendin sath. or: A	[달	Natural 5 Pending 2-19-10	11:03		unknown	1	D. J. D. to Number City
	Division spital or Attend tours after death.	Certification:	3 Suicide 6 x Could not be 28e. Place of Injury -		et, factory, office building, e	tc. 28f. Location (Street and Number of State) 50 Sum own, Md.	Rural Route Number, City mitt Ave. Apt.4425
	Division ospital or Attend hours after death uneral Director: y filled in by the	Se	4 Homicide determined (Specify) house		and at the time, data and of			
	Div To the Hospital of within 24 hours at To the Funeral It completely filled	<u> </u>	one) 2 Medical Examiner: On the basis of examination	on and/or investiga	ation, in my opinion, death o	ccurred at the time, date	and place, and due to	the cause(s)
	Tot with Tot	Medical	29b. Signature and title of certifier		29c. License number		29d. Date signed (I	
		-	110 = A 1600		O.C.M.E.		February 20, 2	010
			30. Name and address of person who completed cause of death (MD 6:00:		
			Margarita Korell MD. Assistant Medical Exa		Penn Street, Baltimore	e, MD 21201 		
	5	tate	31. Date filed (Marts Day Year)	nature Acr	es			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 8, 2010 **Physician** Sendmyer Mullican Albert 1759 M /Medical 4a. Facility Name (If not institution, give street and number)
815 Merry Go Round Way 4c. County of Death 4b. City, Town, or Location of Death Examiner Mount Airy Carroll 8. Date of Birth
(Month, Day, Year)

December 9, 1933 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex **Funeral** Days Hours Months 217-28-5594 1 **X** M 2 □ F 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Mount Airy Director Carroll Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò death with 815 Merry Go Round Way 21771 United States 23a Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★Yes 2 □ No Kore
If Yes, Give
Year or Dates: War items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Korean 1 Never Married 2 Married ō 1 ☐ Yes 2 🛣 No Specify. Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Politics** Liaison 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Lighter Albert Sendmyer Mullican, Sr. ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau once. Kathryn J. Mullican / Wife 815 Merry Go Round Way, Mount Airy, Maryland 21771 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) February 13, 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery Frederick, Maryland 2010 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servi 22. Name and Address of Facility Keeney & Basiord P.A. Funeral Home 106 E. Church Street M01433 Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Par disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 5 ☐ Other (specify) ed by the a ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No uperlipidemia 1 □Yes 2 No funeral director, 25. Wa c e referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical within 24 ho

To the Fune

completely f and manner stated.

State Registrar 29b. Signature and title of certifi-

ORI

30. Name and address 1/00

10

2x

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

who completed cause of death (Item 23a) (Type, Print)

32. Registr

2010

29c. License number

29d. Date signed (Month, Day, Year)